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ROLE OF DIET IN ACNE VULGARIS SEVERITY

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Keywords: acne vulgaris, diet, glycaemic load, Mediterranean diet, chocolate, sunflower seeds.

Summary

Background: The association between diet and acne vulgaris remains controversial despite renewed interest in nutritional modulation of skin disease. This systematic review evaluated the role of diet in acne vulgaris by synthesizing primary interventional studies published between 2015 and 2025.

Materials and Methods: A PubMed search was performed using terms such as "acne AND diet", "acne AND glycaemic", "acne AND chocolate", and "acne AND ketogenic". After duplicate removal and title/abstract screening, 12 interventional studies met the eligibility criteria. Data on study design, population, intervention, outcomes, and limitations were extracted and summarized narratively.

Results: Of the 12 included studies, six assessed specific dietary patterns, including four low-glycaemic load/index interventions and two Mediterranean-style diets. Three evaluated chocolate consumption, two assessed caloric restriction approaches (VLCKD and Ramadan fasting), and one examined sunflower seed intake. Low-glycaemic and Mediterranean dietary patterns generally showed favourable metabolic or clinical effects, whereas chocolate and sunflower seed intake were associated with worsening acne. Caloric restriction approaches also showed potential benefit, although evidence remains limited.

Conclusions: Diet appears to play a contributory role in acne vulgaris severity. The current evidence supports low-glycaemic and Mediterranean-style diets as potentially beneficial, while chocolate and sunflower seeds may aggravate acne. However, the available evidence is limited by small sample sizes, short follow-up, and study heterogeneity. Diet should therefore be considered an adjunct rather than a substitute for conventional acne treatment.

Introduction

Acne vulgaris is one of the most common skin diseases worldwide, with an estimated global prevalence of approximately 9.4%, underlining its importance as a public health concern [1]. It presents with a spectrum of lesions including open and closed comedones, papules, nodules, cysts, and sometimes scarring. Beyond the physical manifestations, acne may cause significant psychological burden, including anxiety, depression, and social withdrawal [2].

Its pathogenesis is multifactorial, involving increased sebum production, follicular hyperkeratinisation, colonization with *Cutibacterium acnes*, and inflammation of the pilosebaceous unit [3]. Hormonal changes, especially androgen stimulation during puberty, are central to disease development and explain the predominance of acne in adolescents [4]. Genetic, lifestyle, and environmental factors such as temperature, humidity, and air pollution may further influence disease severity [5].

Although pharmacological therapies such as retinoids, antibiotics, and hormonal treatment have advanced acne management considerably [6], interest in modifiable lifestyle factors has increased. Stress, sleep quality, and diet are among the most frequently discussed factors [7]. Diet is particularly relevant because it is modifiable and many patients already attempt dietary changes in hopes of improving acne, regardless of professional guidance [8,9].

The role of diet in acne has long been debated. Some earlier authors dismissed dietary influence as unscientific [10], whereas others noted that avoidance of chocolate, fats, sweets, and carbonated beverages was commonly recommended in dermatology texts [11]. During the last two decades, evidence has re-emerged linking certain dietary patterns with acne. Diets high in glycaemic index or glycaemic load may worsen acne through insulin and IGF-1 signalling, which stimulate sebaceous activity and androgen production [12]. Dairy intake has also repeatedly been associated with acne prevalence in observational studies [13]. In contrast, diets rich in whole foods, healthy fats, antioxidants, and fibre—

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such as Mediterranean or very-low-carbohydrate ketogenic diets—have been suggested to improve acne severity through anti-inflammatory and metabolic effects [14].

However, the evidence remains inconsistent. Many available studies are cross-sectional and rely on self-reported dietary questionnaires, which are vulnerable to recall bias and cannot establish causality [15]. Interventional studies are fewer, often short, and methodologically heterogeneous. Some randomized trials have shown improvement with low-glycaemic-load interventions [16], whereas others did not find clear differences compared with standard diets [17]. Similar uncertainty exists regarding chocolate: early controlled studies found no effect [18], whereas more recent work suggests that chocolate may worsen inflammatory lesions in susceptible individuals [19]. As a result, both patients and clinicians are often left with unclear and sometimes contradictory messages [20].

Therefore, a systematic evaluation of dietary interventions in acne vulgaris is warranted.

This review aims to summarize recent interventional evidence, identify the dietary factors most frequently investigated, and assess whether dietary modification influences acne severity.

Methodology and Materials

This systematic review evaluated dietary interventions in acne vulgaris in studies published between January 2015 and June 2025. The review followed PRISMA 2020 guidelines [21]. PubMed was searched using a combination of controlled vocabulary and free-text terms, including “Acne AND food”, “Acne AND diet”, “Acne AND nutrition”, ”Acne AND dairy”, “Acne AND milk”, “Acne AND whey”, “Acne AND glycaemic”, “Acne AND sugar”, “Acne AND probiotics”, “Acne AND Mediterranean”, “Acne AND ketogenic” , “Acne AND tea”, “Acne AND drinks”, “Acne AND supplements”, “Acne AND carnivore”, “Acne AND paleo”, “Acne AND vegetarian”, “Acne AND fasting”, “Acne AND western”, “Acne AND chocolate”, “Acne AND fatty acids”, “Acne AND fish”, and “Acne AND meat”. Records were exported to Zotero, where duplicates were removed automatically and manually.

The inclusion criteria were: (1) randomized, prospective, or retrospective human studies; (2) publications in English; (3) full-text availability; (4) studies evaluating dietary changes in patients with acne; (5) participants diagnosed with acne; and (6) publication within the last 10 years.

The exclusion criteria were: (1) studies not evaluating the effect of diet in acne patients; (2) case reports or case series; (3) experimental studies; (4) non-English publications; (5) unavailable full texts; (6) reviews or meta-analyses; and (7) studies published more than 10 years earlier.

Eligible studies were primary interventional studies involving acne patients exposed to a defined dietary intervention or dietary comparison. Outcomes of interest included lesion count, acne severity, or validated acne scoring systems.

The search yielded 1,883 records. After removal of 765 duplicates, 1,118 records underwent title and abstract screening. At this stage, 341 secondary studies, 7 non-English papers, 18 animal or in vitro studies, 11 supplementation-only studies, and 723 non-interventional, non-dietary, or irrelevant reports were excluded, leaving 18 reports for full-text retrieval. One full text could not be obtained. Of the 17 retrieved studies, 5 were excluded for not meeting the interventional or dietary criteria. Twelve studies were included in the qualitative synthesis. The selection process is presented in the PRISMA flow diagram (Figure 1).

Data extraction was performed using a standardized Excel sheet including author, year, study population, sample size, dietary intervention, comparator, outcomes, main findings, and reported strengths and limitations. Because of heterogeneity in interventions and outcomes, results were synthesized narratively. No formal risk-of-bias tool was applied; instead, methodological limitations were described in the synthesis.

Results

Overview of included studies. Twelve interventional studies were included (Table 1). Six evaluated dietary patterns, three examined chocolate consumption, two assessed caloric restriction, and one investigated sunflower seed intake.

Six studies assessed dietary patterns, primarily low-glycaemic load/index and Mediterranean-style diets.

Low-glycaemic interventions showed mixed but generally favourable results. Burris et al. demonstrated reduced IGF-1 levels without changes in other metabolic markers [21]. Raza et al. reported improvement in both glycaemic load and acne severity following dietary counselling [22]. Pavithra et al. observed metabolic improvements but no additional clinical benefit beyond benzoyl peroxide [17]. Morales-Sánchez et al. found improved inflammatory lesions and global assessment scores when a low GI/GL diet was combined with pharmacological treatment [24].

Mediterranean-style interventions also suggested potential benefit. Bertolani et al. reported lower IGF-1 levels in patients following a Mediterranean diet compared with a Western pattern [25]. Guertler et al. observed improvement in both biochemical markers and acne severity following Mediterranean dietary counselling combined with omega-3 supplementation [26].

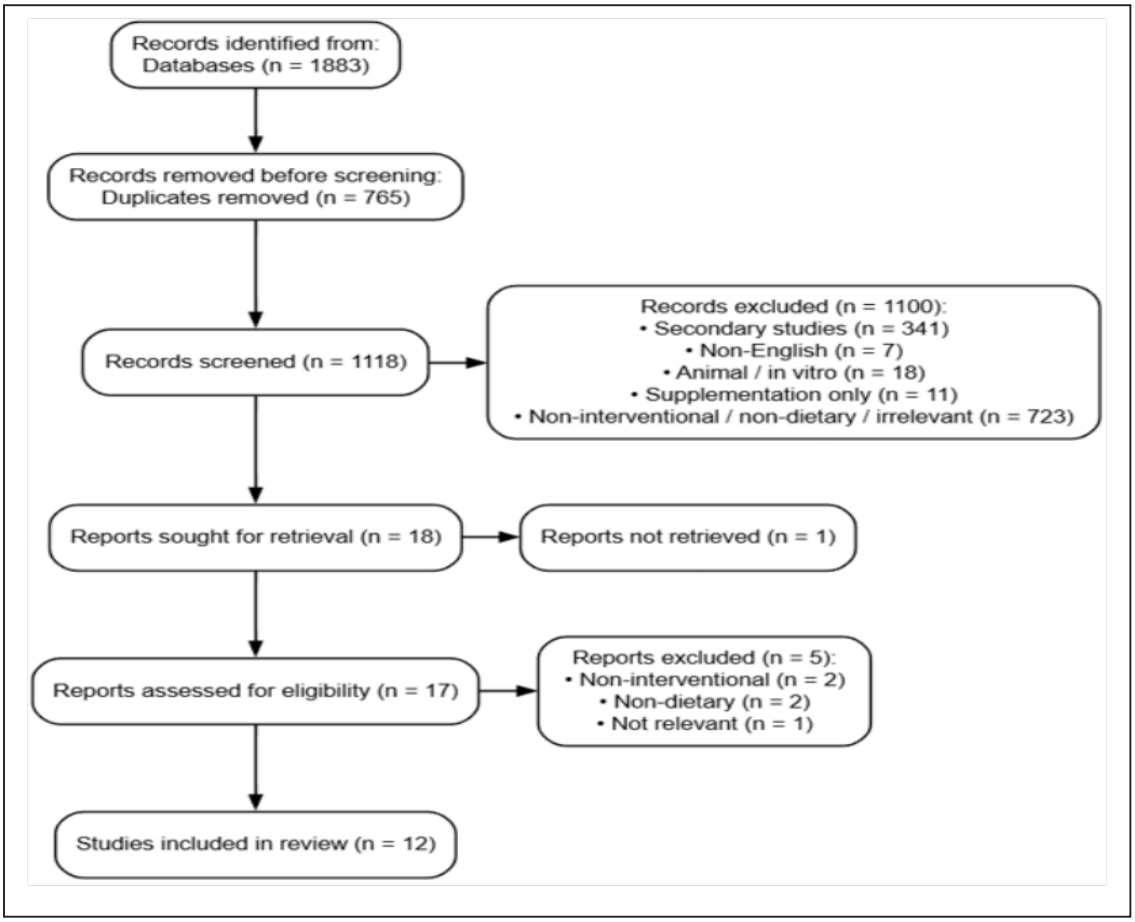


Figure 1. PRISMA 2020 flow diagram of study selection

Overall, these studies suggest that low-glycaemic and Mediterranean dietary patterns may influence metabolic pathways and, in some cases, acne severity.

Chocolate and acne. Three studies consistently reported worsening of acne following chocolate consumption.

Vongraviopap et al. observed increased lesion counts and acne severity after daily chocolate intake [27]. Daszkiewicz et al. reported worsening acne severity during chocolate consumption even within an anti-inflammatory dietary context [28]. Delost et al. demonstrated increased acne lesions after chocolate intake compared with a glycaemically matched control [29].

Caloric restriction. Two studies evaluated caloric restriction approaches.

Verde et al. reported improvement in acne severity and quality of life following a very-low-calorie ketogenic diet [30]. Omar et al. observed reduced acne severity and inflammatory markers after Ramadan fasting [31].

These findings suggest a potential role of caloric restriction in modulating acne-related inflammatory pathways.

Other. One study assessed sunflower seed intake.

Mohebbipour et al. found increased acne severity following sunflower seed consumption compared with controls [32].

Across all subgroups, dietary interventions demonstrated variable effects, with beneficial trends observed for low-glycaemic and Mediterranean diets, and worsening associated with chocolate and sunflower seeds.

Discussion

This review synthesised 12 interventional studies published between 2015 and 2025 examining dietary modification in acne vulgaris. Overall, the evidence suggests that diet may influence acne severity, primarily as an adjunct rather than a standalone treatment. The most relevant mechanisms across studies include glycaemic regulation, IGF-1 signalling, inflammation, and oxidative stress.

Low-glycaemic load interventions were the most frequ-

Table 1. Specific dietary patterns.

Author, Year	Country / Design	Population	Intervention	Main Findings	Strengths & Limitations
Burris et al., 2018	USA / RCT	66 adults, moderate–severe acne, 2 weeks	Low GI/GL diet vs. usual diet	↓ IGF-1 (–22.8 ± 56.6 vs +1.6 ± 40.8 ng/ml, p<0.05). No significant changes in insulin, glucose, or HOMA-IR.	Strength: biochemical outcomes included. Limitation: short duration.
Raza et al., 2024	Pakistan / RCT	50 females, 14–35 yrs, mild–moderate acne, 12 weeks	Low GL diet + counselling vs. usual diet	↓ GL scores (50.2→39.2 vs control unchanged, p<0.001). ↓ acne grade (2.68→1.56 vs control p<0.001).	Strength: individualized counselling, longer duration. Limitation: small sample.
Pavithra et al., 2019	India / RCT	84 participants, 14–29 yrs, acne grades 1–3, 12 weeks	Low GL diet + benzoyl peroxide vs. benzoyl peroxide only	Both groups ↓ acne lesions (p<0.05), no difference between groups (p=0.931). Low GL diet ↓ insulin resistance and BMI (p=0.0001).	Strength: randomized design. Limitation: concurrent treatment, self-reported diet charts.
Morales-Sánchez et al., 2022	Mexico / RCT	44 males, 18–25 yrs, moderate acne, 12 weeks	Low GI/GL diet + adapalene+doxycycline vs. same drugs only	Greater ↓ inflammatory lesions (pustules –9.1 vs –0.96, p=0.028). ↓ PGA (–2.1 vs –1.0, p=0.0001).	Strength: dermatologist evaluation. Limitation: concurrent treatments, small sample.
Bertolani et al., 2022	Italy / NRCT	35 acne pts (14–30 yrs), on pharmacological treatment	Mediterranean diet vs. Western diet	Lower IGF-1 in MD vs WD (270.9 vs 350.5 ng/ml, p=0.027). No GAGS difference.	Limitations: small WD group (n=8), non-randomized, concurrent treatments, small sample.
Guertler et al., 2024	Germany / Prospective	60 acne pts, no drug treatment, 16 weeks	Mediterranean diet + algae-based omega-3 supplement	↑ HS-Omega-3 Index (deficiency ↓ 98%→8%, p<0.001). 79% improved acne, ↓ lesions (p<0.001). ↓ DLQI (4.9→2.4, p<0.001).	Strengths: biochemical + clinical measures, counselling. Limitations:no control group, possible conflict of interest.
Vongraviopap et al., 2016	Thailand / Single-arm	25 males, 18–35 yrs, acne grades 1–4, 4 weeks	25 g/day 99% cacao chocolate	↑ Leeds scores (2.04→2.48, p<0.01). ↑ comedones (11.8→20.3, p<0.01). ↑ papules (6.6→13.7, p<0.01).	Strength: weekly follow-up. Limitations: small sample, no control group, possible evaluator bias.
Daszkiewicz et al., 2024	Poland / Crossover	92 participants (94% female), acne grades 1–4, 8 weeks	Anti-inflammatory diet ± 50 g/day 85% chocolate	↑ GAGS after chocolate in both sequences (Group A: 2.5→3.4, p<0.0001; Group B: 2.4→3.5, p<0.0001).	Strength: crossover design, structured diet Limitations: short intervention blocks.
Delost et al., 2016	USA / Single-blind cross-over	54 university students, 48h per exposure	43 g milk chocolate vs. 15 jelly-beans (equal GL)	Chocolate: +4.8 lesions vs jelly-beans: –0.7 (p<0.0001). Adequate washout confirmed.	Strength: controlled glycaemic load. Limitations: single exposure,
Verde et al., 2024	Italy / Single-arm	31 females, 18–30 yrs, moderate acne, 45 days	Very-low-calorie ketogenic diet (VLCKD)	↓ GAGS (24.3→16.5, –31%, p<0.001). ↓ DLQI (14.6→7.3, –45%, p<0.001). Most shifted from moderate→mild acne.	Strengths: adherence checked via ketone testing + questionnaires. Limitations: no control group, small sample, short duration.
Omar et al., 2025	Egypt / Quasi-experimental	40 pts (85% female, 15–25 yrs), 29 days	Ramadan fasting (sunrise–sunset)	↓ GAGS (20.2→17.9, –11.6%, p≤0.001). ↓ IL-17 (p=0.015). ↓ IFN-γ (p≤0.001). ↓ MDA (p=0.004).	Strengths: biochemical + clinical outcomes. Limitations: no control, short duration, small sample.
Mohebbipour et al., 2015	Iran / RCT	50 females, 15–30 yrs, 2 weeks	25 g/day sunflower seeds vs. avoid seeds	↑ ASI (62→86.8 vs control +4.9; p<0.001). No GAGS change. 88% had ≥10% ASI increase vs 36% controls.	Strength: RCT design. Limitations: short duration, , no mechanistic insight.

ently studied. Burris et al. demonstrated short-term biochemical changes [22], Raza et al. showed clinical improvement [23], and Morales-Sánchez et al. reported enhanced outcomes when diet was combined with pharmacological therapy [24]. In contrast, Pavithra et al. did not observe additional clinical benefit beyond benzoyl peroxide despite metabolic improvements [17]. These findings suggest that low-glycaemic diets may improve metabolic parameters and, in some cases, acne severity, although results remain inconsistent and dependent on study design and concurrent

treatment. This aligns with earlier observational data linking high-glycaemic diets with acne [12,15].

Mediterranean-style interventions also showed potential benefit. Bertolani et al. reported lower IGF-1 levels in patients following a Mediterranean pattern [25], while Guertler et al. demonstrated improvement in both biochemical markers and clinical outcomes when combined with omega-3 supplementation [26]. These results are consistent with the anti-inflammatory profile of such diets [14], although limitations include small sample sizes and lack of controlled designs.

Chocolate consumption was consistently associated with worsening acne across three studies [27–29]. Despite differences in methodology, all reported increased lesion counts or severity. The underlying mechanism remains unclear, as cocoa, sugar, and fat may all contribute. However, the consistency of findings supports a potential aggravating role.

Caloric restriction approaches also suggested benefit. VLCKD improved acne severity and quality of life [30], while Ramadan fasting was associated with reduced inflammatory markers and lower GAGS scores [31]. These findings support the hypothesis that metabolic and inflammatory pathways are involved, although both studies were limited by short duration and lack of controls.

Sunflower seed intake was associated with increased acne severity in a single study [32]. Although evidence is limited, this finding suggests that not all dietary components exert beneficial effects.

Overall, the evidence remains limited by small sample sizes, short follow-up, lack of blinding, and frequent use of concurrent treatments. Adherence assessment was often based on self-report, with only a few studies including objective measures. These methodological limitations likely explain inconsistencies between studies and differences from observational findings [15,19].

An important observation is the absence of recent interventional studies evaluating dairy restriction, despite strong observational associations between dairy intake and acne [13,14]. This represents a relevant gap for future research.

Conclusion

1. The role of diet in acne vulgaris can be considered cautiously supportive. Across 12 interventional studies, low-glycaemic and Mediterranean-style diets were generally associated with improvement, whereas chocolate and sunflower seeds were linked to worsening acne. Caloric restriction approaches also showed potential benefit, although evidence remains limited.

2. However, the available studies are heterogeneous and often limited by small sample sizes, short duration, lack of controls, and reliance on self-reported adherence. These limitations contribute to inconsistencies with previously reported observational associations [15,19].

3. Notably, despite repeated observational links between dairy intake and acne [13,14], no recent interventional studies directly evaluated dairy restriction, representing an important research gap.

4. Overall, dietary modification may improve acne severity but should be considered an adjunct to standard treatment rather than a replacement. Further well-designed randomized controlled trials are needed to establish clear dietary recommendations.

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MITYBOS POVEIKIS AKNĖS SUNKUMUI: SISTEMINĖ APŽVALGA

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Raktažodžiai: aknė, mityba, glikeminis krūvis, Vidužemio jūros dieta, šokoladas, saulėgrąžos.

Santrauka

Įvadas. Mitybos ir aknės vulgaris ryšys tebėra diskutuotinas, nepaisant didėjančio susidomėjimo mitybos poveikiu odos ligoms. Šios sisteminės apžvalgos tikslas – įvertinti mitybos poveikį aknės sunkumui, analizuojant 2015–2025 m. publikuotus intervencinius tyrimus.

Metodai. PubMed duomenų bazėje atlikta paieška naudojant šiuos raktažodžius anglų kalba: „acne AND diet“, „acne AND glycaemic“, „acne AND chocolate“, „acne AND ketogenic“ ir kt. Atrinkta 12 intervencinių tyrimų. Tyrimų dizainas, tiriamųjų populiacija, taikytos intervencijos ir rezultatai analizuoti aprašomuoju būdu.

Rezultatai. Šešiuose tyrimuose vertinti mitybos modeliai: keturiuose – žemo glikeminio indekso arba krūvio dietos, dviejuose – Vidužemio jūros dieta. Trijuose tyrimuose nagrinėtas šokolado vartojimas, dviejuose – kalorijų ribojimas, viename – saulėgrąžų sėklų vartojimas. Žemo glikeminio krūvio ir Vidužemio jūros dietos dažniausiai buvo susijusios su aknės pagerėjimu, o šokolado ir saulėgrąžų vartojimas – su jos pablogėjimu.

Išvados. Mityba gali turėti įtakos aknės sunkumui, tačiau šiuo metu ji turėtų būti laikoma papildoma, o ne pagrindine gydymo priemone. Reikalingi didesnės apimties ir metodologiškai solidesni tyrimai.

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