Anticipate Hyperpigmentation in Dark Skin Acne

Therapies such as retinoids and benzoyl peroxide may trigger irritation and cause the skin to darken.

BY MICHELE G. SULLIVAN
FROM THE AMERICAN ACADEMY OF DERMATOLOGY’S ACADEMY 2010 MEETING

CHICAGO – Patient education is just as important as clinical therapy when treating acne in skin of color.

Even the best acne treatments can cause post-inflammatory hyperpigmentation in dark skin, Dr. Heather Woolery-Lloyd said.

“I always tell patients that these medications can be a little irritating and if you feel too dry or irritated, go to every other day or discontinue its use and try something else, because they can develop hyperpigmentation if the irritation continues,” said Dr. Woolery-Lloyd, director of ethnic skin care at the Bauman Cosmetic and Research Institute, Miami.

Black patients have about a 29% incidence of acne—a very common cause of hyperpigmentation. “The hyperpigmented acne macule is very common,” she said. “But, in black skin, comedonal lesions also show significant histologic signs of inflammation. So, if you are treating acne in skin of color, you’re also going to be treating hyperpigmentation.”

In this tendency, physicians should help patients understand the potential risks, as well as the benefits, of acne therapies. For example, she said, “About 5% of the population is sensitive to benzoyl peroxide. Black patients who are sensitive can develop an irritation that results in hyperpigmentation.”

Retinoids can cause the same problem. “Some [physicians] avoid retinoids in dark skin, but I don’t. I educate my patients; they decrease the frequency of use to three times a week if irritation develops. If they do have hyperpigmentation associated with retinoids, it’s going to come on very suddenly but also it typically resolves after the agent is discontinued.”

Tretinoin and tazarotene are the most likely culprits, she said; adapalene is less likely to cause hyperpigmentation.

Minocycline can also cause an overall darkening of the skin. “I recently saw a patient with darkening of the lips, and have also seen reports of darkening of scars and lesions of the legs,” Dr. Woolery-Lloyd said. “For this reason, I don’t use minocycline as my first line of antibiotic therapy.”

If you treat a lot of acne in skin of color, you’ll also use a lot of hydroquinone, for dealing with post-inflammatory hyperpigmentation, she said. The drug is available in 2% strength over the counter, 4% prescription strength and can be compounded at strengths of 6%-8%.” In my practice I use the 6%-8%. It’s very important to instruct the patient to apply it only to the affected area and to avoid long-term use. I don’t go longer than 2 months, and then I maintain results with a different therapy.”

Some patients—particularly blacks from South Africa—can develop ochronosis, a paradoxical darkening of skin associated with long-term hydroquinone use, she said. “It always starts with erythema, so again, tell your patients to discontinue if they have any irritation.” After erythema, ochronosis manifests blue-black patches that can contain milia, papules, and nodules. “Histologically you see a classic banana-shaped, ocher-colored pigment in the dermis, which can be surrounded by a granulomatous response.” Although 60% of her patients are black, Dr. Woolery-Lloyd said she only sees one or two cases of ochronosis each year. “It’s typically seen in patients who have been using over-the-counter hydroquinone every day for 20-30 years, without sunscreen,” she said. “You have to emphasize to them to stop using it immediately.”

A small subset of patients will have an allergic reaction when using hydroquinone—typically to the sodium metabisulfite preservative in the cream. “If they continue use, the irritation can cause a very severe hyperpigmentation,” she added.

A tip for applying hydroquinone is to carefully treat only the hyperpigmented area—and not by applying the cream with a fingertip. If rubbed around, the cream can cause a halo type affect of circular lightening. “I tell [patients] to use just a small amount and apply it with a cotton swab right on the lesion. And if they apply their retinoid on top of that, it will help to disperse it.”

Dr. Woolery-Lloyd has received research funding and honoraria from Alergen, which manufactures tazarotene, and is on the advisory board and has received honoraria from Galderma, which manufactures adapalene.

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Topical, Oral Agents Show Promise as Skin Cancer Defense

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CHICAGO – In the not-too-distant future, dermatologists may be sending patients to the beach with a bagful of chemoprevention tricks to outwit ultraviolet radiation and reduce the risk of sun-related skin cancers.

“In addition to sunscreen, we’ll be using these chemopreventive agents not only to reduce histologic response to ultraviolet light, but to repair the DNA damage that occurs as a result of overexposure to the sun,” said Dr. Craig Elmets. “Instead of sending patients to the beach, cover up with long pants, long sleeves, and a hat, we can send them off to engage in their normal behavior with less worry about the long-term consequences.”

Sunscreen remains the first line of defense against cancer-inducing ultraviolet radiation, but they need backup, said Dr. Elmets, professor and chair of the department of dermatology and director of the Skin Disease Research Center at the University of Alabama, Birmingham. “They are greasy and messy, and people don’t really enjoy applying them. And most people don’t use nearly enough to achieve the sun protection factor stated on the label; in fact, studies show use nearly enough to achieve the 25% of the necessary amount.” Sunscreens also have limited effect on sun protection factor stated on the label; in fact, studies show use nearly enough to achieve the 25% of the necessary amount.” Sunscreens also have limited effect on...