

Laser Plus Resurfacing Best for Tattoo Removal

'Patients uniformly preferred the combined treatment side for recovery,' noting less blistering and pain.

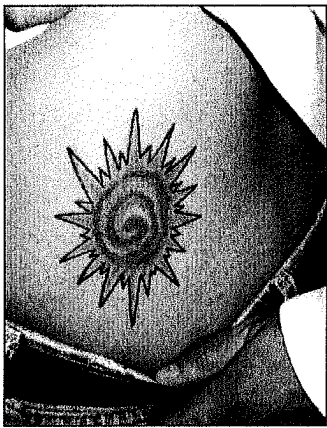
BY DAMIAN McNAMARA

FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY

CHICAGO – Tattoo removal using a combination of Q-switched laser and ablative and nonablative fractional resurfacing treatment yielded better outcomes than did laser treatment alone, a small study has shown.

No scarring, no bullae formation, and no infection were observed with combination treatment in this split-comparison study of 10 tattoos after a total of 43 treatments.

"One of the most interesting observations is patients uniformly preferred



Yellow iron oxide pigments can be targeted with the dual laser treatment.

the combined treatment side for recovery [in terms of] less blistering and pain, and they were able to leave it open to the air sooner," Dr. Elliot T. Weiss said at the meeting.

"In some patients, it appeared equivocal to me in terms of outcome, but patients in each case preferred wound healing with combined therapy," said Dr. Weiss, a dermatologic surgeon in private practice in New York City and Southampton.

N.Y. Q-switched laser treatment is the most common approach to tattoo removal. However, some patients are left with incomplete clearance and/or permanent hypopigmentation, Dr. Weiss said.

He theorized that tattoo clearance would be improved by two fractional resurfacing properties: enhanced inflammatory phagocytic response and prevention of fluid accumulation and blistering with fenestration of the epidermis and dermis.

"You can begin to treat yellow and white iron oxide pigments," he said. "It still requires multiple treatments, but [the results] are still better than with Q-switched ruby alone."

Multiple treatments were required on both sides for each previously untreated

tattoo. Participants had the tattoos for an average of 11 years.

Participants reported increased clearance of tattoo pigment with the combined treatment on four tattoos and equivocal clearance in the remaining six tattoos, compared with the side treated

with laser only (Dermatol. Surg. (2010 Nov. 12 [doi: 10.1111/j.1524-4725.2010.01821.x]).

A meeting attendee asked which of the combination treatments Dr. Weiss uses first. "I found it more useful to use the ruby [laser] first so you can see where you treated," he said. "The other way around, it was harder to see pigment changes."

Because the tattoos were not homogeneous, it was difficult in some cas-

es to see a dramatic difference in pigment clearance. However, optical coherence tomography revealed some more dramatic differences in the split-tattoo treatments. The combined treatment side showed no blistering, for example, compared with formation of blisters on the Q-switched ruby laser-only sides.

Dr. Weiss said that he had no relevant financial disclosures.

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*n = 115,001
†n = 92,054
††Prescription claim data from SDI Health LLC, 2010

ACZONE® (dapsone) Gel 5% is indicated for the topical treatment of acne vulgaris.

Important Safety Information

WARNINGS AND PRECAUTIONS

Hematological effects: Oral dapsone treatment has produced dose-related hemolysis and hemolytic anemia. Individuals with glucose-6-phosphate dehydrogenase (G6PD) deficiency are more prone to hemolysis with the use of certain drugs. There was no evidence of clinically relevant hemolysis or anemia in patients treated with ACZONE® Gel 5%, including patients who were G6PD deficient. Some subjects with G6PD deficiency using ACZONE® Gel 5% developed laboratory changes suggestive of mild hemolysis. If signs and symptoms suggestive of hemolytic anemia occur, ACZONE® Gel 5% should be discontinued. ACZONE® Gel 5% should not be used in patients who are taking oral dapsone or antifolate medications because of the potential for hemolytic reactions. Combination of ACZONE® Gel 5% with trimethoprim/sulfamethoxazole (TMP/SMX) may increase the likelihood of hemolysis in patients with G6PD deficiency.

Peripheral neuropathy: Peripheral neuropathy (motor loss and muscle weakness) has been reported with oral dapsone treatment. No events of peripheral neuropathy were observed in clinical trials with topical ACZONE® Gel 5% treatment.

Skin: Skin reactions (toxic epidermal necrolysis, erythema multiforme, morbilliform and scarlatiniform reactions, bullous and exfoliative dermatitis, erythema nodosum, and urticaria) have been reported with oral dapsone treatment. These types of skin reactions were not observed in clinical trials with topical ACZONE® Gel 5% treatment.

ADVERSE REACTIONS

The most common adverse reactions of ACZONE® Gel 5% (incidence ≥ 10%) are: oiliness/peeling, dryness, and erythema at the application site.

DRUG INTERACTIONS

Topical application of ACZONE® Gel followed by benzoyl peroxide in subjects with acne vulgaris resulted in a temporary local yellow or orange discoloration of the skin and facial hair (reported by 7 out of 95 subjects in a clinical study) with resolution in 4 to 67 days.

Please see brief summary of full prescribing information on the adjacent page.

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Reference: 1. SDI Health LLC. Acne Market Patient Counts by Ethnicity—Limited Brands. Plymouth Meeting, PA: SDI Health LLC; 2010.

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