TO THE EDITOR:
Dr. Bensimon’s article about croton oil peels (Aesthetic Surg J 2008;28:33-45) is an excellent and elegantly illustrated eye-opener about the efficacy of phenol peels. Unfortunately, it appears that this unique and superb procedure, as originally gifted to us by Baker and Gordon, has become (inappropriately and unfairly) greatly underutilized.

However, regarding the skin pretreatment recommended by Dr. Bensimon—incorporating tretinoin and/or glycolic acid, phytic acid, and hydroquinone—I would caution practitioners to carefully assess the risk/reward ratio. Not only is there uncertainty about the influence of this pretreatment on the final result, but pretreatment also introduces another variable, the effect of which may not be recognized. Moreover, because this regimen is self-administered by the patient at home, there is no controlling the intensity of treatment. The uncontrolled, unmonitored pretreatment regimen, through an unmeasured, intrinsic peeling activity, may promote a deeper skin peel—the undesired result of successive but additive skin treatments. Stegman1 discussed the potential “…adverse effect on the end result of the peel” should there be prior destruction of the epidermal barrier, “which allows penetration of the peeling agent.”

The alternative approach, incorporating fewer variables, is to rely solely on the phenol and croton oil peel without pretreatment. Using this method, the process is completely controlled by the administering physician. Should the patient develop postinflammatory hyperpigmentation, it can then be dealt with appropriately. Today, there are a wide variety of bleach creams that are universally successful in hastening the resolution of hyperpigmentation. Because the consequences of overzealous skin peeling are so disturbing, “Primum no nocere.”

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DISCLOSURES
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REFERENCE

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Dr. Bensimon Replies:
I am appreciative of Dr. Kotler’s complimentary remarks, and I am happy to see that he recognizes the value of croton oil peels. With regard to his comments about pretreatment with tretinoin, hydroquinone, and glycolic or phytic acid, I would like to expand on the purpose of such pretreatment. On a cellular level, the stratum corneum of the epidermis is compacted, the melanocytes are suppressed, and there is a more even blending of pigment deposition. This regulation of cell function reduces the risk of postoperative hyperpigmentation. The fibroblasts are stimulated to create more collagen and elastin, and angiogenesis increases the circulation of the skin. In essence, the skin is “revved up” in preparation for the injury to come. Skin prepared in this manner has been shown to respond better to resurfacing, and it is useful no matter what modality is used.

There is some controversy as to the necessity of this preparation, but when I have omitted or shortened it in light-eyed patients, these patients have suffered erythema that is intense and of an excessively long duration. The best way to treat postoperative hyperpigmentation is to prevent it and, in my experience, the regimen that I outlined in my article is the best choice.

Dr. Kotler voices a concern that using an “…uncontrolled, unmonitored regimen” consisting of tretinoin and hydroquinone before peeling can lead to problems. My response is simply that his fears are unfounded. The use of tretinoin is ubiquitous worldwide, and its safety is a matter of record. The Obagi Nu-Derm System (Skin Specialists PC, Omaha, NE) is perhaps the most widely doctor-prescribed skin regimen—not only for its efficacy, but also for its safety. The risk/reward ratio is overwhelmingly positive for any practitioner who uses retinoic acids, and I recommend them to virtually all my patients, whether or not they are contemplating a peel.
I quite agree that the consequences of overzealous skin peeling, laser resurfacing, or dermabrasion are very disturbing; I disagree that the use of tretinoin and hydroquinone is a contributing factor.

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