skinthings

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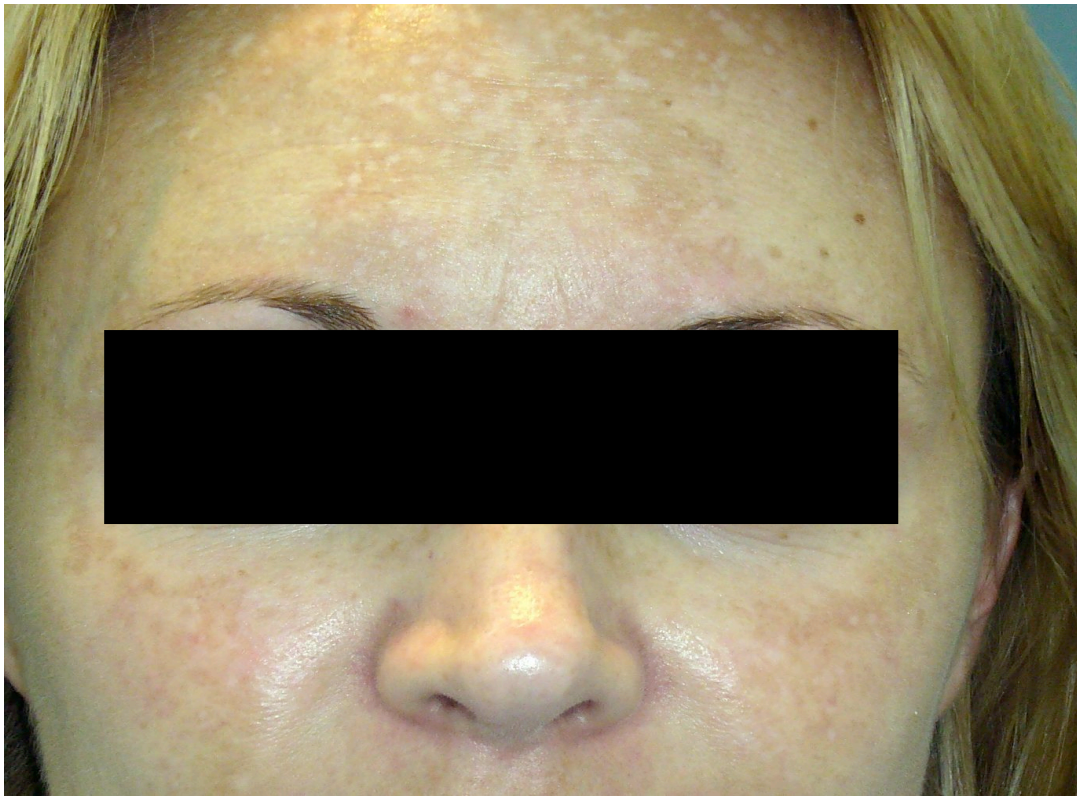
Mask of pregnancy

A woman develops a facial hyperpigmentation while pregnant.



A 29-YEAR-OLD woman presents with a mottled facial hyperpigmentation that started during her pregnancy.

She is 12 months post-partum and the appearance has only improved slightly. She has tried many different over-the-counter fading creams with no significant improvement. She is currently on the oral contraceptive pill. How can this woman be helped?

THE PROBLEM

Chloasma, or mask of pregnancy, describes facial hyperpigmentation in response to hormonal changes during pregnancy that is aggravated by sunlight. Melasma refers to a similar facial hyperpigmentation in the non-pregnant state. It usually presents bilaterally and symmetrically.

CHLOASMA/ MELASMA KEY FACTS

- Common
- Mainly females
- More common in darker skin types
- Associated with hormones (oral contraceptive pill) and sun exposure
- Can be difficult to treat
- Differential diagnosis: post-inflammatory hyperpigmentation, exogenous ochronosis (hydroquinone overuse), lentigo/freckles, nevus of Ota.

TREATMENT OPTIONS

Sun protection in combination with one or more of the following:

- Topical bleaching creams-containing hydroquinone
- Superficial chemical peels
- Pigment (Q-switched) laser – refractory cases only
- Resurfacing laser (ablative/non-ablative/fractional) – refractory cases only.

Combination topical therapy with hydroquinone and some other bleaching agents (e.g. azelaic acid, retinoids, kojic acid, glycolic acid) can be prescribed for melasma.

Superficial peels with glycolic, lactic or salicylic acid every month will also help. During pregnancy, sun avoidance and sun protection alone is best without attempting skin bleaching until post-partum.

IPL and Q-switched pigment laser can selectively target the hyperpigmentation. This works well in patients of fair complexion. Patients of darker skin type should be treated with caution, as even slight inflammation may worsen the appearance.

Resurfacing lasers are reserved for refractory cases that have failed the above measures.

MANAGEMENT

Firstly, the patient needs to understand the relevant hormonal and UV triggers for her skin condition. Initial Wood's light (UV) examination will determine the degree of epidermal pigmentation, which is more responsive to treatment, and dermal pigmentation.

She will need to use SPF 30+ sunscreen and avoid the sun where possible. This patient was also started on combination topical hydroquinone (4%), kojic acid (4%), retinoic acid (0.025%) and hydrocortisone (1 per cent).

She was reluctant to stop the Pill as a method of contraception, despite understanding that this may be an aggravating factor.

This is an informed patient decision that is reasonable and should be respected, as the condition is of aesthetic concern only.

Hydroquinone should not be used longer than 2-3 months at a time to minimise toxicity and side-effects such as paradoxical darkening of the treated areas. Retinoids or azelaic acid can be used instead for maintenance.

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