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Acne and scarring

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Eighty to ninety percent patients with acne have atrophic scars (subdivided into boxcar, icepick, or rolling), while few have hypertrophic scars. Treatment requires different approaches with choice of treatment being based on scar type. Dermabrasion, useful in softening sharper scar edges, involves use of diamond embedded fraises attached to hand piece that evenly abrades skin to papillary dermis. In subcision, a hypodermic, tribevelled, or filter needle is introduced into subdermal plane to undermine scars. Skin needling involves vertically puncturing the skin to release scar tissue and promote neocollagenesis. For icepick scars, punch excision, elevation, and grafting are used. In punch excision, a scar is removed with punch biopsy and site is sutured. In punch elevation, punched-out scar is elevated to level of surrounding skin which heals secondarily. In punch grafting, scar is excised and a full-thickness skin graft is positioned. Chemical Reconstruction of Skin Scars (CROSS) technique of TCA application minimizes side effects of scarring and dyspigmentation and is used for icepick scarring. Deeper peels like phenol can be used to treat scars. Hyaluronic acid (HA) fillers are used for rolling acne scars. New technique known as subdermal minimal surgery allows precise and even radial dispersion of HA into dermal planes. Poly-L-lactic acid (PLLA) has been used successfully for atrophic acne scars. Calcium hydroxyapatite semi-permanent filler has shown to improve rolling scars. Autologous fibroblast transfer (AFT) represents newer filler techniques for scarring. Laser resurfacing has emerged at the forefront of acne scar treatment. Various lasers used are ablative CO_2 and Er:YAG lasers, erbium-doped 1550 nm laser and ablative fractionated CO_2. Concurrent use of fractional laser skin resurfacing with punch elevation is effective. Picoseconds pulse duration with diffractive lens array may be a new technological advancement. Role of activated platelets in severe acne scarring has been reported.

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Platelets rich plasma versus minoxidil 5% in treatment of alopecia areata: A trichoscopic evaluation

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Alopecia areata is a common cause of nonscarring alopecia that occurs in a patchy, confluent, or diffuse pattern. Dermoscopy is a noninvasive technique for the clinical diagnosis of many skin diseases. Topical minoxidil solution 5% and platelet rich plasma are important modalities used in treatment of alopecia areata. We aimed to evaluate the efficacy of PRP versus topical minoxidil 5% in the treatment of AA by clinical evaluation and trichoscopic examination. Ninety patients were allocated into three groups; the first was treated with topical minoxidil 5% solution, the second with platelets rich plasma injections, and the third with placebo. Diagnosis and follow up were done by serial digital camera photography of lesions and dermoscopic scan before and every 1 month after treatment for 3 months. Patients treated with minoxidil 5% and platelets rich plasma both have significant hair growth than placebo ($p<0.05$). Patients treated with platelets rich plasma had an earlier response in the form of hair regrowth, reduction in short vellus hair and dystrophic hair unlike patients treated with minoxidil and control ($p<0.05$). In conclusion, platelets rich plasma is more effective in the treatment of alopecia areata than topical minoxidil 5% as evaluated by clinical and trichoscopic examination.

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