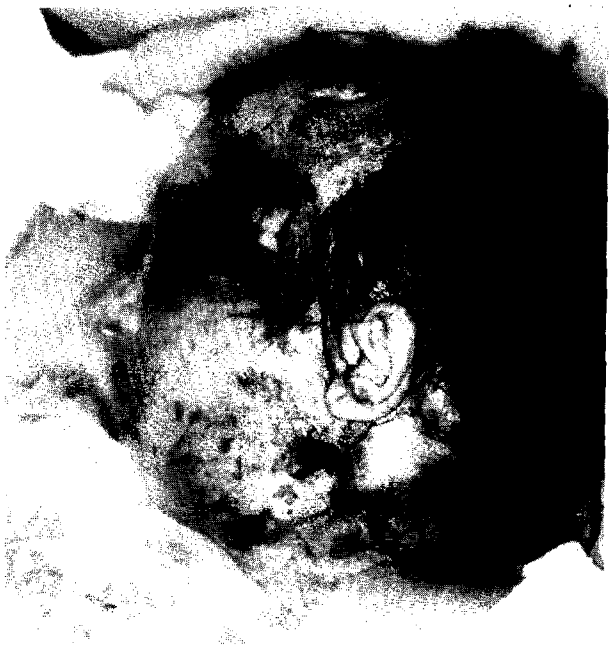

Figure

Figure—Necrotising fasciitis involving the head and neck.

The patient had systemic signs of sepsis and other complications. She died despite a radical debridement of all affected tissues. This case illustrated the aggressiveness of these infections, especially in AIDS patients.

Yours faithfully,

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Darrier's disease

Sir,

We have recently been faced with a dilemma in the management of a patient with Darrier's disease, a rare severe nodulo-cystic skin condition, affecting predominantly the face and midline of the body. Our patient had received various courses of Isotretinoin (Roaccutane) under the care of the dermatologists with only limited success. It had, therefore, been suggested that facial dermabrasion might be of cosmetic benefit in amelioration of the disfiguring facial scarring.

This case has highlighted an important point for surgeons. Review of the dermatological literature underlines the danger of these two forms of treatment when combined together.

The use of the Retinoids, in particular Isotretinoin (Roaccutane), in the management of severe recalcitrant acne and other seborrhoeic skin conditions has to some extent revolutionised their management, producing rapid clearing and prolonged periods of remission.[1] One course is often enough to achieve a satisfactory disease free state. Residual facial scarring, however, can be a problem and for this reason, patients may present to the plastic surgery department for facial dermabrasion. It should be remembered that a significant number of these patients may be on concurrent Isotretinoin therapy, or may have recently finished a course of treatment.

Various reporters have encountered undesirable complications following dermabrasion of patients either on, or having recently finished, a course of treatment.[2,3] The main problems identified with dermabrading such patients are those of delayed wound healing and, more importantly, atypical keloid scarring appearing two to four months after the initial dermabrasion. Interestingly, the keloid scars occur in unusual sites, for example the cheeks and forehead.

Isotretinoin and its derivatives have been shown to have diverse effects on the metabolic activity of the skin and, in particular, on fibroblast activity. Its potency as a drug against acne lies in its ability to depress the activity of the pilo-sebaceous unit dramatically. It has been postulated that this may be an important factor in delayed wound healing – the pilo-sebaceous unit being important in the re-epithelialisation process. Isotretinoin has also been shown to suppress collagenase activity in keloid fibroblast cultures,[4] a fact which has led to the speculation that this may be a mechanism by which keloid formation is promoted, or, at least, not inhibited.[2]

It is difficult to explain the abnormal scar sites, however, it is possible that in altering the biochemical and physiological nature of the skin, its mechanical properties are also affected and this interaction may contribute to abnormal scar formation.

Different authors advocate varying time intervals between stopping Isotretinoin treatment and commencing dermabrasion. Some have advocated a wait of as long as one to two years before undertaking such treatment.[5] Though this may appear to be a long time, it should be remembered that the effects of Isotretinoin are longlasting and it would seem prudent to wait for a period of at least three to six months before undertaking dermabrasion in a patient who has been on Isotretinoin.

Yours faithfully,

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