

Melasma Referral Guideline

Indications for Specialty Care Referral

- Refer patients with melasma unresponsive to 6 months of conventional treatment.

Criteria for Return to Primary Care

- Condition has resolved and/or a suitable treatment plan has been established.

Diagnosis/Definition

- Melasma (chloasma, dyschromia [ICD-9 709.09] is a skin condition characterized by symmetric, sharply demarcated brown patches on the malar prominences, forehead and occasionally the chin, forearms, and/or external genitalia. It is accentuated by exposure to sunlight.
- Melasma occurs predominantly in women and especially during pregnancy in the 2nd or 3rd trimester, in women going through menopause, and in women on oral contraceptive pills.
- Melasma may occur in otherwise normal women (10% of presentations are men).

Initial Diagnosis and Management

- General – Document education regarding known causes of Melasma as stated above. Consider a temporal association with a new medication, as several medications enhance photosensitivity. Emphasize that patients **MUST minimize sun exposure and wear a complete sun block daily.**
- Melasma of pregnancy usually clears within several months of delivery and clearance upon stopping OCPs may take many months. For obvious reasons, improvement may be slower in the sunny summer months and more rapid during the darker winter months. Differential diagnosis for the disorder includes lentigo and postinflammatory hyperpigmentation.
- Start treatment with application of a bleaching agents **containing hydroquinone 2-4% to affected areas bid.**
- Only spot treat the lesions to hasten clearance of melasma. Patients can obtain OTC bleaching creams such as Porcelana (2%) or prescription concentrations such as Melanex (3%) solution (on formulary) or hydroquinone 4% Eloopaque Forte (formulary). Note: A paradoxical response of darkening of the already dark area may occur after prolonged use of some topical bleaching agents.
- A topical retinoid, **tretinoin cream bid 0.025%, 0.05%, 0.1%; tretinoin gel 0.025%, (formulary)** can be used synergistically with hydroquinone or as a monotherapy. Most patients cannot tolerate a potent strength and should begin with 0.025% or 0.05% cream. Explain that Retin-A, tretinoin, frequently causes some redness and scaling which improves with time and can be minimized by closely following prescribing advice. Retin-A may be applied to broad areas, but bleaching creams should be applied as a spot treatment only on areas of hyperpigmentation. Of note, Kligman's formula- combining a bleaching agent,

Retin-A, and a mild topical steroid (Lustra is an OTC example of such a combination product) - is purported to be very effective therapy.

Ongoing Management and Objectives

- Minimization of dyschromia is the primary objective of treatment.
- If there is minimal improvement at 12 weeks, review medication use and compliance. Education that the key ingredient in any given regimen is sunscreen / sun protection.
- Encourage patient to continue regimen even if only mild improvement is seen. Start with a bleaching agent by itself or in conjunction with Retin-A. If patient is adherent with medications and is still dissatisfied with results, try adding a mild topical steroid such as desonide 0.05% cream (class VI) or fluocinolone 0.01% solution (class VI)– applied sparingly twice daily) for a few weeks to the regimen.