The fact was that the previously painful calciphylactic secondary to hemodialysis. However, the impressive arose from systemic lupus erythematosus or was nephritis. It is not clear whether the calciphylaxis undergoing hemodialysis for the treatment of lupus young woman with systemic lupus erythematosus, resolution of extensive calciphylactic lesions in a ASCT. In this context Mandelbrot et al result of end-stage renal disease) may benefit from tissue disease, but also calciphylaxis (in most cases a not only dystrophic calcinosis cutis in connective the letter of Dr Velez and colleagues is the fact that must be performed for each patient. What we miss in and dendritic cells.

and T lymphocytes, monocytes, natural killer cells, immune diseases. A favorable response of the effect of ASCT may be regarded as the key factor in autoimmune diseases. We agree with the author's suggestion that ASCT might be a reasonable choice for the treatment of extensive lifestyle-limiting and painful dystrophic calcinosis cutis that does not respond to traditional therapy. In ASCT, conditioning with high-dose cyclophosphamide, antithymocyte globulin, and/or total-body irradiation nullifies the majority of autoreactive effector cells involved in the adaptive and innate immune response, including B and T lymphocytes, monocytes, natural killer cells, and dendritic cells. Thus, the immunosuppressive effect of ASCT may be regarded as the key factor in autoimmune diseases. A favorable response of the underlying disease to ASCT will logically lead to the resolution of all accompanying symptoms, including skin calcification. Nevertheless, one should keep in mind the fact that the transplant-related mortality is approximately 7%, whereas transplant-related toxicity registered 2 years after ASCT was as high as 33%. Therefore, a careful risk-benefit evaluation must be performed for each patient. What we miss in the letter of Dr Velez and colleagues is the fact that not only dystrophic calcinosis cutis in connective tissue disease, but also calciphylaxis (in most cases a result of end-stage renal disease) may benefit from ASCT. In this context Mandelbrot et al described the resolution of extensive calciphylactic lesions in a young woman with systemic lupus erythematosus, undergoing hemodialysis for the treatment of lupus nephritis. It is not clear whether the calciphylaxis arose from systemic lupus erythematosus or was secondary to hemodialysis. However, the impressive fact was that the previously painful calciphylactic lesions had healed fully after ASCT treatment and the patient required no further medication for pain relief. In conclusion, ASCT may be regarded as a maximal variant of immunosuppressive therapy in autoimmune diseases and even reverses calcinosis cutis. We suggest ASCT as a therapy option for patients with severe therapy-refractory dystrophic calcinosis caused by autoimmune disease and in patients with extensive calciphylaxis.

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REFERENCES


Evidence for fractional laser treatment in the improvement of cutaneous scars

To the Editor: We read with great interest the article by Tziotzios and colleagues describing strategies to reduce cutaneous scarring, published in January 2012. This valuable review article very briefly touches on fractional laser therapy for scars, and comments that “there is a limited evidence base to support use of fractional laser therapy.”

We have had extensive, favorable clinical experience with nonablative and ablative fractional lasers for scarring (Fig 1) that is strongly supported by several objective, peer-reviewed published studies that were not included in this review. We believe the readership would benefit from review of these studies and their demonstration of significant efficacy and evidence for improvement of scars. These include a study of 53 patients with

Fig 1

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atrophic scars treated with a nonablative 1550-nm erbium-doped fractional laser that showed 51% to 75% improvement as assessed by independent investigators in nearly 90% of the patients. In addition, a study at our center of 15 women with atrophic scars treated with 3 ablative fractional carbon-dioxide laser treatments showed improvements in skin texture, pigmentation, atrophy, and overall scar appearance, along with objective improvement by image analysis showing 38% mean volume reduction and 35% mean depth reduction. For acne scars, a study of 13 patients with moderate to severe facial acne scars demonstrated a mean 66.8% improvement in the depth of scars by objective 3-dimensional topographic imaging analysis after 2 to 3 treatments with an ablative fractional carbon-dioxide laser. Improvement in thermal burn scars was seen in a randomized controlled blinded trial of 17 patients treated with a 1540-nm nonablative fractional laser that showed statistically significant improvement in the evenness and smoothness of scars ($P = .0015$) and reported 8 of 17 patients believed there was moderate or significant improvement.

The aforementioned studies are a sampling of published data using new and innovative approaches to scar management that we believe should often be considered the treatment of choice for atrophic scars, acne scars, and some hypertrophic and burn scars. Awareness of these advances will allow physicians to provide or refer their patients for the optimum improvement of the appearance and physical limitations of scarring.

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REFERENCES


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Reply

To the Editor: We thank Dr Reddy et al for their comments and for suggesting a wider review of current evidence for the use of fractional lasers in the treatment of scars. The focus of our CME series was on the molecular pathobiology of hypertrophic and keloid scarring and on strategies to avoid or treat such scarring after dermatologic procedures, as conveyed by the titles of each part. We had therefore not evaluated treatments for atrophic scars nor those after burns or acne.

The evidence for fractional laser treatment in keloid or hypertrophic scarring remains limited. In addition to the study by Tierney et al, quoted in the CME article, other small studies of fractional laser therapy with short follow-up have suggested some improvement, insignificant improvement, or a reduced risk of hypertrophic scarring. Some