MELASMA

A. Marked melasma.

B. The ultra-violet (UV) light shows an increased contrast between lesional and healthy skin suggestive of a mostly epidermal form of melasma.

SYNONYMS
Chloasma, pregnancy mask.

EPIDEMIOLOGY
The condition is common (up to 30% of women of child-bearing age in some populations). Ilil skin types can be affected but more frequent in Asian and Hispanic populations.

Incidence: 1:10. Most patients are affected during the third decade of life, but onset of the lesions after 40-50 years of age is observed in 14% and 6% of cases, respectively.

Onset of the disease is found to be earlier in light skin types, while dark skin types (V and VI) are usually associated with a late onset of melasma (even post-menopausal).

Medical studies have shown that only 20% of melasma harassed in the peri-menopausal period. Moreover, the correlation of at-risk patients resemble a weak impact on the evolution of melasma and the impact of hormonal treatment is even higher in cases of familial history of melasma.

CLINICAL DERMATOLOGICAL PRESENTATION
Light to dark brown hyperpigmentation. Symmetrical distribution with irregular border. Worsening in summer period.

Wood's lamp examination allows to assess if the melasma is mostly epidermal or dermal. However, recent studies using laser confocal microscopy showed that all melasmas are mixed with a strong heterogeneity within the same lesion.

Asymptomatic.

Localization: Central pattern (forehead, nose, medial part of the cheeks, upper lip, chin) (accounts for more than 60% of cases) / Malar pattern (cheeks and nose) / Mandibular pattern.

Chronic evolution for 10 to 20 years.

EXTRACUTANEOUS SIGNS
None.

HISTOPATHOLOGY
Hyperpigmentation of the basal and supra-basal layers of the epidermis sometimes associated with pendulous melanocytes.

Pigmentary incontinence.

Elastosis and vascular ectasia.

DIFFERENTIAL DIAGNOSIS
- Acquired bilateral nevus of Ota-like macules.
- Post-inflammatory hyperpigmentation.
- Linea fusca.
- Riehl's melanosis.
- Ertythrose peribuccale pigmentaire de Brocq.

TREATMENT
Strict avoidance of sunlight.

Avoid friction and irritative procedures.

The Kligman's formulation remains the gold standard treatment.

Peeling can be proposed in secondary intention.

Cosmetic depigmentation agents can be proposed for maintenance treatment.

Q-switched lasers are not a good option for melasma.

KEY REFERENCES
MELASMA

Melasma affecting only the malar area.

Melasma in a man.

Mild melasma with a central pattern.

Melasma with a post-menopausal onset.
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