Australasian Society of Cosmetic and Procedural Dermatologists

IN THIS ISSUE

Procedural Skills for Benign Skin Lesions — Part 2

OPINIONS AND PROGRESS IN

Cosmetic Dermatology

VOLUME 05 / ISSUE 01 / SEPTEMBER 2025

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Cosmetic Dermatology
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Procedural Skills for Benign Skin Lesions

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References: 1. Fabi SG, Joseph J, Sevi J, Green JB, Peterson JD. Optimizing patient outcomes by customizing treatment with microfocused ultrasound with visualization: gold standard consensus guidelines from an expert panel. J Drugs Dermatol.2019;18(5):426-432. 2. Ulthera Instructions For Use. 3. Pavicic T, Ballard J, Bykovskaya T, Corduff N, Hirano C, Park JY, Saromytskaya, Sevi J, Vasconcelos S. Microfocused ultrasound with visualization: Consensus on safety and review of energy-based devices. J Cosmet Dermatol. 2022;21:636–647. 4. Fabi SG, Massaki A, Eimpunth S, Pogoda J, Goldman MP. Evaluation of microfocused ultrasoundwith visualization for lifting, tightening, and wrinkle reduction of the décolletage. J Am Acad Dermatol. 2013;69(6):965-971. 5. Park JY, Lin F, Suwanchinda A, et al. Customized Treatment Using Microfocused Ultrasound with Visualization for Optimized Patient Outcomes: A Review of Skin-tightening Energy Technologies and a Pan-Asian Adaptation of the Expert Panel's Gold Standard Consensus. J Clin Aesthet Dermatol 2021;14(5):E70-e79. 6. Werschler WP, Werschler PS. Long-term Efficacy of Micro-focused Ultrasound with Visualization for Lifting and Tightening Lax Facial and Neck Skin Using a Customized Vectoring Treatment Method. J Clin Aesthet Dermatol. 2016 Feb;9(2):27-33.

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OPINIONS AND PROGRESS IN
Cosmetic Dermatology
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DERMATOLOGY TRADECRAFT — PART 2

Procedural Skills for Benign Skin Lesions

Welcome to *Dermatology Tradecraft Two* – a continuation of last year's Tradecraft edition, once again featuring numerous practical video demonstrations for the management of both benign and selected malignant skin conditions.

I would like to extend my sincere thanks to Dr Shobhan Manoharan and Dr William Cranwell, two esteemed Brisbane dermatologists who have generously taken on the role of guest editors for this issue. Together, we have curated thirteen high-quality clips covering a broad spectrum of conditions, from rosacea and melasma through to varicose veins and actinic dysplasia.

I am also deeply grateful to Dr Adrian Lim, who, in addition to his new role as President of the Australasian College of Dermatologists, has served as Editor-in-Chief of this publication since its inception. With his guidance, Opinions and Progress in Cosmetic Dermatology has established itself as a valuable educational resource. As Dr Lim steps into his new responsibilities, my colleagues Dr Aakriti Gupta, Dr Sarah Hannam, and I are honoured to serve as rotating Editors-in-Chief.

We trust you will find this issue both informative and practical. As always, we welcome your feedback to help us refine future editions and continue to meet your educational needs.

Editor-in-Chief
Dr Shreya Andric

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DERMATOLOGY TRADECRAFT — PART 2

Procedural Skills for Benign Skin Lesions

Contents — continued

PROCEDURAL CLIPS — continued

Guest Editorial

Dr Shobhan Manoharan

Correspondence: Dr Shobhan Manoharan (pictured left) info@drmanoharan.com.au

Manoharan S. Guest Editorial. *Opin Prog Cosmet Dermatol.* 2025;5(1):1.

Welcome the eleventh issue of *Opinions and Progress in Cosmetic Dermatology*, which continues our exploration of "Dermatology Tradecraft." In Part 1, we showcased practical, everyday procedures for benign skin lesions.

In this edition, we shift our focus to physical therapies and energy-based devices, with an emphasis on lasers, light sources, and other advanced technologies for cosmetic dermatology. These tools are integral to modern practice. For many patients, energy-based treatments are among the most visible and immediate ways that dermatologists can address concerns such as pigmentation, vascular changes, texture irregularities, and skin laxity.

One of the challenges for both new and established practitioners is navigating the sheer variety of platforms, wavelengths, and delivery systems now available. Each device promises to be "the most versatile" or "the gold standard," yet our role as dermatologists is to interpret the evidence, understand the physics, and apply these tools with precision to deliver safe, reproducible results. Tradecraft, in this context, is about more than simply knowing which button to press – it's about recognising the subtleties of skin response, tailoring fluence and pulse duration, anticipating adverse events, and combining modalities when appropriate to optimise outcomes.

This issue brings together contributions from colleagues who not only have deep technical expertise, but also the ability to distil complex procedural knowledge into practical pearls. You will find procedural clips demonstrating core techniques and nuanced adjustments that can make the difference between a good result and an exceptional one. From fractional laser resurfacing for scarring, to targeted vascular laser therapy for persistent erythema, to the judicious use of intense pulsed light for photorejuvenation, these insights aim to refine and elevate your approach.

As with all tradecraft, mastery comes from a blend of theoretical knowledge, practical repetition, and learning from the collective experience of peers. My hope is that this issue not only provides technical instruction, but also encourages thoughtful discussion on how we, as a specialty, can continue to advance safe, effective, and evidence-based use of these powerful tools.

Whether you are fine-tuning your parameters for a familiar platform or exploring a new device entirely, I trust you will find value in these contributions. The accessibility of high-quality procedural education is central to our society's mission, and I look forward to seeing how these shared skills translate into improved patient outcomes across our practices.

Dr Shobhan Manoharan
Guest Editor

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PROCEDURAL CLIP

Treatment of Rosacea Using the Candela Vbeam Perfecta Laser

PRESENTED BY
Dr Shreya Andric

CLICK ON IMAGE TO WATCH VIDEO DURATION_01:47

Overview

Rosacea is a chronic inflammatory skin condition that is characterised by facial erythema, telangiectasia, flushing, and—in some cases—papulopustular lesions. Vascular lasers, such as the Candela Vbeam Perfecta, are highly effective for targeting the vascular components of rosacea, helping to reduce persistent redness and visible blood vessels.

The Vbeam Perfecta is a pulsed dye laser that operates at a 595-nm wavelength. It selectively targets oxyhaemoglobin within blood vessels, delivering controlled energy to coagulate and gradually eliminate unwanted superficial vasculature with minimal damage to the surrounding skin.

Treatment protocol

- Skin is cleansed prior to the treatment and protective eyewear is worn.
- Topical anaesthetic is not usually required because an incorporated dynamic cooling device enhances patient comfort and protects the epidermis.
- Specific parameters—including spot size, pulse duration, and energy fluence—are selected based on the patient's skin type and the severity of vascular involvement.
- Multiple passes may be performed, focusing on areas of diffuse erythema or prominent telangiectasia.
- Some patients may experience mild purpura, transient swelling, or erythema post-treatment; this typically resolves within a few days.
- A course of 2–5 sessions, spaced 4–6 weeks apart, is commonly recommended for optimal results.

Key benefits

- Gold standard for treating vascular features of rosacea.
- Quick treatment with minimal downtime.
- Safe across a range of skin types when appropriate settings are selected.
- Can improve not only redness and vessels but also associated symptoms such as flushing and burning.

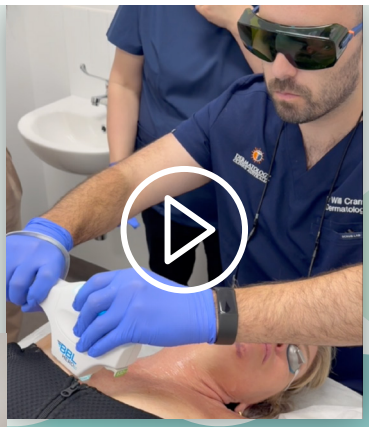
Considerations

- Patients must avoid sun exposure pre- and post-treatment.
- Post-laser care includes gentle skincare, sun protection, and avoidance of heat exposure (including heavy exercise) for a few days.
- Rosacea is a relapsing condition; maintenance treatments should be performed every 6–12 months.

Andric S. Treatment of Rosacea Using the Candela Vbeam Perfecta Laser. *Opin Prog Cosmet Dermatol.* 2025;5(1):3.

PROCEDURAL CLIP

Treatment of Lentigines Using BroadBand Light (BBL) Heroic by Sciton



PRESENTED BY
Dr William Cranwell

CLICK ON IMAGE TO WATCH VIDEO DURATION_03:40

Overview

Solar lentigines are benign pigmented lesions that commonly arise in sun-exposed areas; they are caused by chronic ultraviolet radiation. The BroadBand Light (BBL) Heroic platform by Sciton offers a high-speed, large-spot, non-ablative method to address pigmentation, vascular dyschromia, and photodamage with minimal downtime. This document outlines a typical approach to treating lentigines—particularly on the face, chest, arms, and hands—using a tiered BBL strategy.

Patient selection

- Suitable for Fitzpatrick Skin Types I–III with discrete lentigines and photodamage.
- Patients with melasma, recent tanning, or active retinoid use should be excluded or pretreated using pigment stabilisation strategies.
- Clinical examination should be used to rule out atypical lesions; dermoscopy is recommended to ensure that no malignant features are present.

Treatment strategy

The BBL Heroic platform enables a two-step approach to pigmentation:

1. **Base pass (532 nm):**
   A large-spot, even pass across the treatment zone is performed using a 532-nm filter. This pass targets general background pigment and field damage. Energy is delivered quickly and efficiently across broad areas; this is especially useful for the upper limbs and chest, where lentigines are often widespread. The 532-nm filter also effectively treats vascular changes related to actinic exposure.
2. **Spot treatment (515 nm):**
   Focused pulses are then applied to darker, more resistant lentigines using the 515-nm filter, which has stronger melanin absorption and greater specificity for superficial pigment.

   Advanced cooling, integrated within the BBL handpiece, provides epidermal protection, thus enabling the safe delivery of high fluence where needed without compromising comfort or safety.

continue to next page

Cranwell W. Treatment of Lentigines Using BroadBand Light (BBL) Heroic by Sciton. *Opin Prog Cosmet Dermatol.* 2025;5(1):4–5.

Treatment of Lentigines Using BroadBand Light (BBL) Heroic by Sciton — continued

Endpoint and response

- Pigmented lesions typically darken immediately post-treatment, appearing grey or black.
- Mild erythema and oedema are expected and often resolve within hours.
- Over subsequent days, treated lentigines microcrust and exfoliate, revealing clearer skin.
- Most patients observe visible improvement within 7–10 days, with progressive results over 2–3 weeks.

Post-treatment care

- Daily application of a bland emollient until exfoliation is complete.
- Strict photoprotection for 4–6 weeks, including broad-spectrum sunscreen and sun avoidance.
- Active skincare products (retinoids, alpha hydroxy acids, vitamin C) should be avoided for several days post-treatment.
- Makeup can typically be resumed the following day if desired.
- Repeat treatment may be considered at 4–6 weeks, depending on the pigment response and patient goals.

Key benefits

- **Rapid, large-area coverage:** Face, chest, or limbs can be treated efficiently with minimal discomfort.
- **Dual targeting:** Both pigment and vascular components can be selectively treated in the same session.
- **High patient satisfaction:** Consistent improvements in skin clarity and photodamage with minimal downtime.
- **Field-based therapy:** Targets both clinical and subclinical pigmentation, thereby improving skin homogeneity.

PROCEDURAL CLIP

Treatment of Lentigines Using the Cutera Enlighten III Picosecond Laser

PRESENTED BY
Dr William Cranwell

CLICK ON IMAGE TO WATCH VIDEO DURATION_03:51

Overview

Lentigines are benign, ultraviolet-induced pigmented lesions that frequently affect sun-exposed areas such as the face, décolletage, and dorsal hands. Although they are benign, they are a common cosmetic concern and frequently present in combination with other signs of photodamage. Picosecond laser technology has revolutionised pigment-targeted therapies by offering ultrashort pulse durations, resulting in greater photomechanical disruption of pigment with reduced thermal diffusion and downtime.

Treatment protocol

Patient selection and pre-treatment

- Ideal candidates have well-defined clinically and dermoscopically confirmed solar lentigines.
- Caution is warranted in Fitzpatrick Skin Types IV–VI due to the increased risk of pigmentary alteration; test spots are advised.
- Pre-treatment photography under cross-polarised and standard lighting is recommended for documentation and outcome assessment.

Laser parameters – Cutera Enlighten III

Wavelength:

- **532 nm** (targeting epidermal pigment) is the primary wavelength for lentigines.
- **1064 nm** may be used for deeper or dermal lesions, or for darker skin types with modified fluence.

Pulse duration:

- **Picosecond mode** (750 ps) preferred for its greater photoacoustic effect and reduced thermal injury.

Anaesthesia:

- Anaesthesia is usually not required; cool air or contact cooling provides sufficient comfort.

continue to next page

Cranwell W. Treatment of Lentigines Using the Cutera Enlighten III Picosecond Laser. *Opin Prog Cosmet Dermatol.* 2025;5(1):6–7.

Key benefits

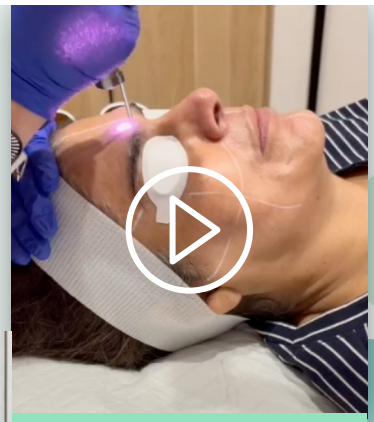
- **High melanin selectivity:**
  The 532-nm wavelength in picosecond pulse duration allows the precise targeting of superficial melanin in lentigines, with minimal disruption to the surrounding skin.
- **Reduced downtime:**
  Compared with Q-switched or nanosecond platforms, picosecond technology reduces thermal collateral damage, leading to faster healing and a lower risk of post-inflammatory hyperpigmentation.
- **Excellent clearance rates:**
  Most patients achieve near-complete clearance in 1–2 sessions, particularly with lighter phototypes and more recent lesions.
- **Versatility across sites:**
  Effective on the face, hands, décolletage, and forearms, including challenging areas with variable skin thickness and photodamage.

Considerations

- **Post-treatment appearance:**
  Transient whitening or pinpoint petechiae may occur; mild erythema and crusting may last 3–5 days.
- **Sun avoidance and photoprotection:**
  This is critical pre- and post-treatment to reduce the risk of post-inflammatory hyperpigmentation, especially in darker phototypes.
- **Multiple sessions:**
  Some lesions may require 2–3 treatments for full clearance, particularly for older, thicker, or dermally pigmented lesions.
- **Test spots:**
  These are advised in patients with darker skin tones or uncertain response, using conservative fluence and close follow-up.

PROCEDURAL CLIP

Treatment of Melasma Using the Lutronic Hollywood Spectra Laser (1064 nm)



PRESENTED BY
Dr Shreya Andric

CLICK ON IMAGE TO WATCH VIDEO DURATION_01:57

Overview

Melasma is a chronic pigmentary disorder that is characterised by irregular, hyperpigmented patches that typically occur on sun-exposed areas of the face. Its pathogenesis is complex, involving genetic predisposition, ultraviolet radiation, hormonal influences, and inflammation. Given its recurrent nature, successful management requires a long-term, multimodal approach.

One effective modality for melasma treatment is the Lutronic Hollywood Spectra laser with the 1064-nm Q-switched Nd:YAG setting. This wavelength is ideal for targeting dermal and epidermal melanin while minimising thermal injury to surrounding tissues, thus reducing the risk of post-inflammatory hyperpigmentation—an important consideration in melasma management.

Treatment protocol

- The Hollywood Spectra uses subcellular photoacoustic energy to gently shatter melanin particles without causing significant heat build-up.
- Typically, a series of treatments is recommended—often, approximately five sessions spaced 3–4 weeks apart.
- Treatment is virtually painless and well-tolerated, with no significant downtime.
- Protective eyewear is mandatory throughout the procedure.
- It is important to be mindful of any tattoos (cosmetic or other); if there are tattoos (e.g., eyebrows/lip), they should be coloured with a white pencil so that the laser does not target the tattoo pigment.
- Skin is cleansed prior to treatment, and a topical anaesthetic is generally not required.
- Skin is marked into credit card-sized areas.

continue to next page

Andric S. Treatment of Melasma Using the Lutronic Hollywood Spectra Laser (1064 nm). *Opin Prog Cosmet Dermatol.* 2025;5(1):8–9.

Treatment of Melasma Using the Lutronic Hollywood Spectra Laser (1064 nm) — continued

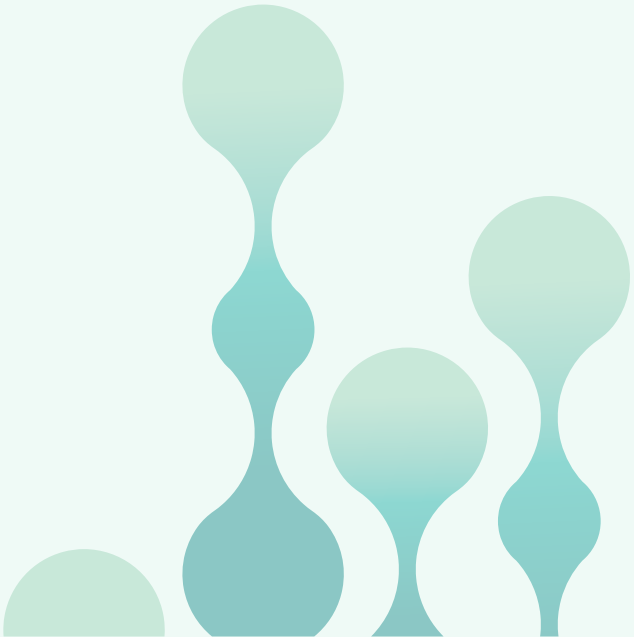
- Using the 1064-nm wavelength, low fluence, and large spot sizes, the laser is passed over the skin in multiple passes (approximately 3–5 passes), with a focus on uniform coverage.
- Post-treatment, patients may experience mild erythema or a slight warming sensation, which typically resolves within a few hours.
- A strict post-care regimen including broad-spectrum sunscreen, pigment inhibitors (e.g., hydroquinone, cysteamine, and tranexamic acid), and sun avoidance is essential to optimise and maintain results.

Key benefits

- Safe for all skin types, including Fitzpatrick Skin Types IV and V.
- Minimal risk of downtime or adverse effects when appropriately administered.
- Can be used in conjunction with other topical therapies for enhanced outcomes.

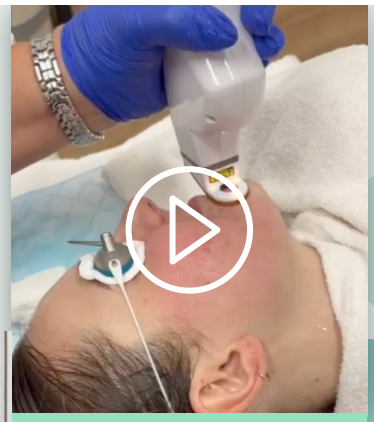
Considerations

- Melasma is prone to recurrence; maintenance treatments and vigilant photoprotection are critical.
- Realistic patient expectations should be set—aiming for improvement, not a cure.
- A holistic approach that addresses hormonal factors, ultraviolet protection, and inflammation is paramount for long-term success.



PROCEDURAL CLIP

Treatment of Active Acne Using the Cutera AviClear Laser



PRESENTED BY
Dr Shreya Andric

CLICK ON IMAGE TO WATCH VIDEO DURATION_01:39

Overview

Acne vulgaris is a multifactorial skin disorder that involves follicular hyperkeratinisation, excess sebum production, bacterial proliferation, and inflammation. Traditional treatments include topical agents, oral antibiotics, hormonal therapy, and isotretinoin. However, some patients require or prefer alternative, non-pharmacologic options.

The Cutera AviClear laser is the first Therapeutic Goods Administration-approved device specifically designed for the treatment of mild, moderate, and severe acne. It uses a 1726-nm wavelength that is uniquely absorbed by sebaceous glands, thereby selectively targeting and suppressing sebum production without damaging the surrounding tissue.

Treatment protocol

- Skin is thoroughly cleansed prior to treatment and protective eyewear is worn.
- A cooling system is integrated into the device to maintain patient comfort and epidermal safety.
- Our practice uses a specially formulated topical anaesthetic that is applied 30–60 minutes prior to the treatment.
- Treatments involve methodical, uniform coverage of the face (300 pulses) or other affected areas; each session takes approximately 30 minutes.
- A series of three treatments, spaced about 4–6 weeks apart, is recommended for best results.
- Minimal downtime is needed, although some patients experience mild redness or swelling for 1–2 days post-procedure.

Key benefits

- Non-invasive and drug-free option for acne management.
- Suitable for a broad range of skin types, including darker phototypes.
- Helps to reduce active acne and may decrease future breakouts by modulating sebum production.
- No significant downtime, allowing a quick return to normal activities.

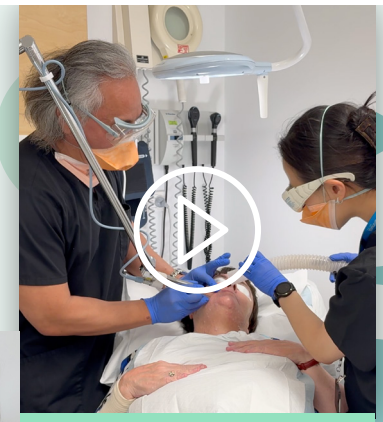
Considerations

- Optimal results develop gradually over several months post-treatment.
- Purging or flare-ups may occur after initial sessions.
- Maintenance treatments may be considered depending on individual response and severity.

Andric S. Treatment of Active Acne Using the Cutera AviClear Laser. *Opin Prog Cosmet Dermatol.* 2025;5(1):10.

PROCEDURAL CLIP

Cutaneous Neurofibroma (cNF-1) Treatment with Laser and Surgery



PRESENTED BY
Dr Adrian Lim

CLICK ON IMAGE TO WATCH VIDEO DURATION_02:26

PROCEDURAL OVERVIEW

Key concepts

- Cutaneous neurofibromas are benign skin tumours that are associated with neurofibromatosis type 1; they present as sessile, globular, pedunculated, or larger lesions.
- Treatment aims include cosmetic improvement and the relief of symptomatic lesions that cause discomfort, pain, or itching.
- Appropriate lesion selection and procedural technique are important for optimal cosmetic and functional results.

Procedural techniques – laser

- Preparation involves topical anaesthetic application with optional occlusion, followed by thorough cleaning using chlorhexidine to reduce the infection risk.
- Spot erbium laser (2–4 mm spot size) targets small, flat, and sessile lesions on sensitive facial and neck areas.
- Laser treatment begins at 8 Hz for patient comfort, with the potential to increase frequency to 12 Hz for enhanced efficiency but also increased discomfort.
- Erbium lasers are advantageous due to the lower risk of hypopigmentation compared with CO_2 lasers; however, they are associated with a higher likelihood of bleeding. Haemostatic agents such as 20% aluminium chloride or silver nitrate should be available.

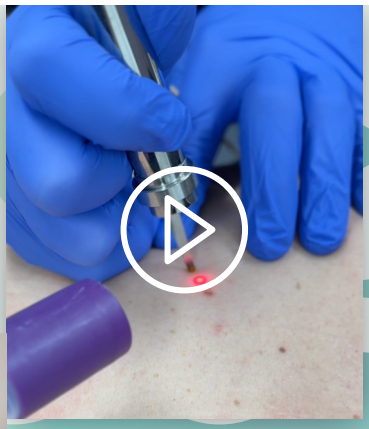
Procedural techniques – double-shave

- Primarily used for larger, symptomatic lesions on the torso and limbs (sessile, globular, and pedunculated lesions).
- Local anaesthetic infiltration ensures patient comfort throughout the procedure.
- **First shave:** Removes protruding neurofibroma, achieving flush alignment with surrounding skin.
- **Second shave:** Essential for removing deeper, embedded gelatinous neurofibroma tissue.
- Forceps aid with lesion stabilisation and visualisation during both shaves.
- Closure involves one or two interrupted sutures, ensuring excellent cosmetic results and effective wound healing.
- Larger-diameter lesions may do better with conventional elliptical excision.

Lim A. Cutaneous Neurofibroma (cNF-1) Treatment with Laser and Surgery. *Opin Prog Cosmet Dermatol.* 2025;5(1):11.

PROCEDURAL CLIP

Management of Benign Skin Lesions Using the Sciton Joule Erbium:YAG Laser



PRESENTED BY
Dr William Cranwell

CLICK ON IMAGE TO WATCH VIDEO DURATION_01:43

Overview

Benign cutaneous lesions such as seborrhoeic keratoses and syringomas are common presentations in dermatology practice. Although they are typically asymptomatic, they may cause cosmetic concern or discomfort. Laser ablation using the Sciton Joule Er:YAG laser (2940 nm) offers a precise, minimally invasive option with brief downtime and superior cosmetic outcomes. This article outlines techniques and parameters for managing raised and flat seborrhoeic keratoses as well as periocular syringomas.

Treatment protocol

Patient selection and assessment

- Suitable for patients with multiple cosmetically bothersome, benign lesions.
- Clinical or dermoscopic confirmation of benign nature prior to treatment is essential.
- For syringomas, differentiation from other adnexal neoplasms is particularly important.

1. Treatment of seborrhoeic keratoses

Device: Sciton Joule Er:YAG (2940 nm)

Settings (typical):

- **Spot size:** 2–4 mm.
- **Microns per pass:** 10–20 µm (conservative).
- **Anaesthesia:** Topical anaesthetic; local infiltration for large or numerous lesions.

Technique:

- Raised seborrhoeic keratoses are gently removed in a controlled manner.
- Multiple passes at relatively low energy mitigate the risk of overtreatment.
- A moistened cotton tip applicator is used to gently wipe away treated debris after each pass. A gentle curette can be used to gently remove larger seborrhoeic keratoses.
- **Endpoint:** flattening of the lesion with visible ablation and minimal thermal effect.

Post-treatment care:

- Bland emollient or white soft paraffin is applied three times daily (TDS) until crusting resolves (typically, 5–7 days).
- Sun protection and avoidance of picking or exfoliation during healing is advised.
- Re-epithelialisation expected within 7–10 days.

continue to next page

Cranwell W. Management of Benign Skin Lesions Using the Sciton Joule Erbium:YAG Laser. *Opin Prog Cosmet Dermatol.* 2025;5(1):12–13.

2. Treatment of syringomas

Device: Sciton Joule Er:YAG (2940 nm)

Settings (typical):

- **Spot size:** 1–2 mm.
- **Microns per pass:** 10–20 µm.
- **Anaesthesia:** Topical anaesthetic cream for 45–60 minutes (carefully placed to avoid contact with the eye). Many patients tolerate treatment without anaesthetic.

Technique:

- Syringomas are treated conservatively to avoid post-inflammatory pigmentary changes.
- Pinpoint, focused ablation with minimal overlapping is used.
- **Endpoint:** flattening with visible surface ablation. Overtreatment should be avoided. The goal is to improve the appearance of, rather than completely ablate, lesions.

Post-treatment care:

- Ophthalmic-grade antibiotic ointment is applied to periocular skin TDS for 3–5 days.
- Cold compresses can reduce swelling.
- Full recovery typically occurs within 5–7 days, with a low risk of scarring.

Key benefits

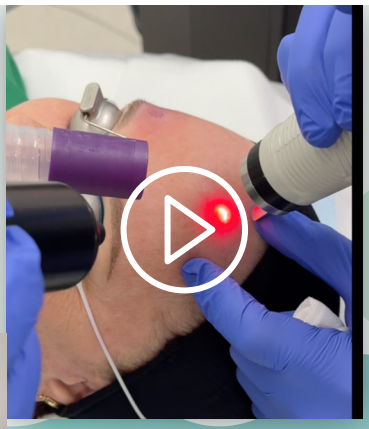
- **Precision and control:**
  Er:YAG ablates with micron-level accuracy and minimal thermal diffusion.
- **Cosmetic outcomes:**
  Smooth healing with reduced risk of post-inflammatory pigmentation compared with cryotherapy or electrosurgery.
- **Patient satisfaction:**
  High rates of cosmetic improvement in a single session with brief downtime.

Considerations

- **Test spots:**
  Recommended for patients with Fitzpatrick Skin Types IV–VI, to assess pigmentary response.
- **Histological uncertainty:**
  Lesions of unclear diagnosis should be biopsied prior to use.
- **Recurrence:**
  Particularly for syringomas, recurrence may occur and maintenance treatments may be necessary.

PROCEDURAL CLIP

Treatment of Actinic Dysplasias Using Lumenis Ultrapulse Alpha CO_2 and Sciton Joule Erbium:YAG Lasers



PRESENTED BY
Dr William Cranwell

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Overview

Actinic dysplasias, including actinic keratoses (AKs) and actinic cheilitis, are common precancerous conditions resulting from chronic sun exposure. Laser resurfacing offers a targeted, tissue-sparing alternative to field-directed topical therapies. This article presents a dual-device approach using the **Ultrapulse Alpha CO_2** laser for facial AKs and the **Sciton Joule Er:YAG** laser for actinic cheilitis.

Treatment protocol

Patient selection and assessment

- Ideal candidates include those with multiple AKs on sun-damaged facial skin or those with actinic cheilitis.
- Pre-treatment evaluation includes dermoscopic assessment, the exclusion of invasive squamous cell carcinoma, and the consideration of patient expectations, downtime tolerance, and comorbidities.
- Photography (with standardised lighting) is essential for documentation and monitoring.

1. Treatment of AKs: Ultrapulse Alpha CO_2

Device: Lumenis Ultrapulse Alpha.

Mode: ActiveFX.

Settings (typical):

- **Anaesthetic:** local infiltration or topical anaesthetic.
- **ActiveFX (for superficial AKs).**
- **Endpoint:** Uniform ablation with pinpoint bleeding or mild frosting.

Post-treatment care:

- White soft paraffin ointment three times daily for 5–7 days.
- Daily saline soaks and photoprotection for 4 weeks.
- Re-epithelialisation typically occurs within 7–10 days.

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Cranwell W. Treatment of Actinic Dysplasias Using Lumenis Ultrapulse Alpha CO2 and Sciton Joule Erbium:YAG Lasers. *Opin Prog Cosmet Dermatol.* 2025;5(1):14–15.

2. Treatment of actinic cheilitis: Sciton Joule Erbium:YAG

Device: Sciton Joule with Contour TRL handpiece.

Laser type: Er:YAG (2940 nm).

Ablative mode settings (typical):

- **Anaesthetic:** mental nerve block and local infiltration.
- **Ablation depth:** 10–15 µm per pulse (modulated by multiple passes).
- **Spot size:** 2–4 mm.
- **Cooling:** External cold-air.
- **Endpoint:** Uniform ablation with visible superficial tissue removal; minimal thermal damage.

Post-treatment instructions:

- Lip emollient or antibiotic ointment to be applied frequently.
- Hot or spicy foods and excessive lip movement should be avoided during healing.
- Epithelial healing occurs within 5–7 days; the complete resolution of actinic changes occurs within 2 weeks.

Key benefits

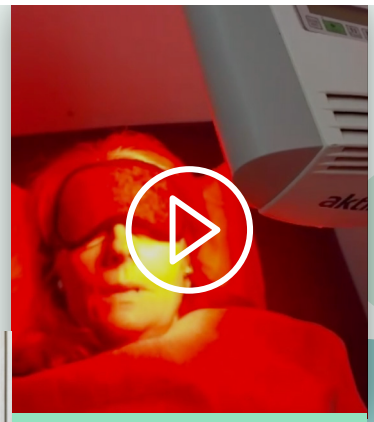
- **Precise tissue ablation:** Both the Ultrapulse CO_2 and Er:YAG lasers offer controlled ablation depth, allowing for the tailored treatment of dysplastic epidermis without damaging deeper structures.
- **Field cancerisation treatment:** Laser resurfacing addresses not only visible AKs but also subclinical dysplasia across sun-damaged skin, thereby reducing recurrence and new lesion formation.
- **Rapid healing and cosmesis:** Compared with cryotherapy or topical treatments, laser therapy may yield smoother, more uniform skin with superior cosmetic outcomes.
- **Single-session clearance:** Especially for actinic cheilitis, Er:YAG laser ablation may achieve complete clearance in a single session, with high long-term remission rates.

Considerations

- **Downtime and aftercare:** Patients must be appropriately counselled regarding post-laser downtime, wound care, and sun protection to ensure optimal healing and minimise complications.
- **Histological uncertainty:** Laser ablation does not provide a histological specimen. In cases of diagnostic uncertainty or suspected invasive squamous cell carcinoma, biopsy prior to laser treatment is essential.
- **Pigmentary risk:** Caution is advised in Fitzpatrick Skin Types IV–VI due to the increased risk of hypopigmentation or post-inflammatory hyperpigmentation. Test spots and adjusted fluence may be necessary.

PROCEDURAL CLIP

Treatment of Superficial Basal Cell Carcinoma Using Photodynamic Therapy with Metvix and Aktilite



PRESENTED BY
Dr Shreya Andric

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Overview

Superficial basal cell carcinoma (BCC) is a subtype of non-melanoma skin cancer that typically presents as a thin, erythematous, scaly plaque. It most commonly occurs on the trunk or limbs and tends to grow slowly. For patients in whom surgery is not preferred or feasible, photodynamic therapy offers a non-invasive, effective alternative with excellent cosmetic outcomes.

Photodynamic therapy using Metvix (methyl aminolevulinate) and the Aktilite red light system selectively targets cancerous cells while sparing surrounding healthy tissue. It works through the light activation of a photosensitising agent, leading to the generation of reactive oxygen species and subsequent cell destruction.

Treatment protocol

- The lesion is prepared with gentle curettage to remove any crusts or scales and enhance Metvix absorption.
- Metvix cream is applied directly to the lesion as well as a small margin; this is then covered with an occlusive dressing.
- After a 3-hour incubation period, the cream is removed, and the area is illuminated with Aktilite red light (630 nm) for approximately 8–10 minutes.
- The procedure is generally well tolerated, although patients often report a stinging or burning sensation during illumination.
- Post-treatment erythema, oedema, and crusting are common, with full healing over 1–3 weeks.

Key benefits

- Effective, non-invasive treatment for selected superficial BCC.
- Preserves surrounding tissue with minimal risk of scarring.
- Excellent cosmetic results, especially in cosmetically sensitive areas.
- Suitable for multiple lesions or larger surface areas.

Considerations

- Indicated for biopsy-confirmed superficial BCC only—not suitable for nodular, infiltrative, or high-risk subtypes.
- Patients must practice strict photoprotection for 48 hours post-treatment.
- Follow-up is essential to assess the response and detect any recurrence or persistence.
- Two treatments, 1–2 weeks apart, are standard.

Andric S. Treatment of Superficial Basal Cell Carcinoma Using Photodynamic Therapy with Metvix and Aktilite. *Opin Prog Cosmet Dermatol.* 2025;5(1):16.

PROCEDURAL CLIP

Burn Scar Repair with Fractional CO_2

PRESENTED BY
Dr Adrian Lim

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PROCEDURAL OVERVIEW

Key concepts

- Fractional CO_2 laser therapy improves burn scar aesthetics, functionality, and patient comfort.
- Its combination with laser-assisted drug delivery (LADD) significantly enhances therapeutic outcomes.
- Procedure effectiveness relies on appropriate patient assessment and technique selection, and diligent aftercare.

Burns scar assessment

- **Visual inspection:**
  Evaluate scar colour, texture, thickness, border definition, and distortion.
- **Palpation:**
  Check firmness and pliability.
- **Functional assessment:**
  Assess range of motion and flexibility, especially for scar contractures.
- **Psychosocial impact:**
  Consider emotional and psychological effects of scar appearance and functionality limitations.

Procedural techniques

- **Preparation:**
  Topical anaesthetic is removed after approximately 45–60 minutes under occlusion, and skin is thoroughly cleansed.
- **Initial laser pass (LADD):**
  Higher-density, lower-fluence settings create superficial micro-channels for drug delivery.
- **Secondary laser pass:**
  Lower-density, higher-fluence settings target deeper, thickened scars and areas of contracture to remodel collagen, enhance flexibility, and restore function.

Laser-assisted drug delivery

- LADD significantly improves the penetration and efficacy of topical medications.
- The immediate post-laser application of Kenacort-A 10 to Kenacort-A 40 enhances therapeutic outcomes by reducing inflammation, redness, and scar hypertrophy, and improves overall scar aesthetics.
- To optimise recovery and results, ongoing post-procedure care involves hydration, gentle skincare, potent topical steroids for 1–2 weeks, and consistent sun protection.

Lim A. Burn Scar Repair with Fractional CO2. *Opin Prog Cosmet Dermatol.* 2025;5(1):17.

PROCEDURAL CLIP

Duplex Ultrasound for Varicose Veins

PRESENTED BY
Dr Adrian Lim

CLICK ON IMAGE TO WATCH VIDEO DURATION_01:01

PROCEDURAL OVERVIEW

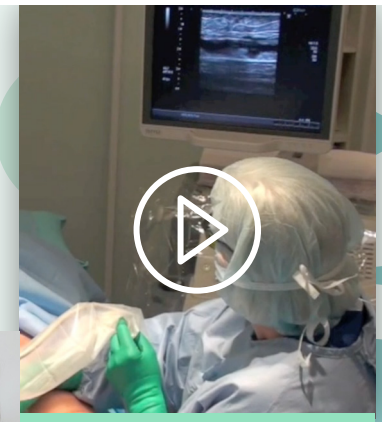
Key concepts

- **Clinical assessment** begins with history and physical examination.
- **Screening duplex** of truncal veins and tributaries is performed to detect venous reflux or abnormal flow.
- **Duplex ultrasound** by a trained sonographer is essential for definitive mapping prior to treatment.
- **Visual inspection** alone is insufficient because many incompetent trunks and perforators are not externally visible.
- **Duplex ultrasound mapping** provides a comprehensive view of the superficial venous system, including:
  - Axial reflux pathways.
  - Perforator competence.
  - Tributary involvement.
- **Accurate identification** of both visible and occult sources of reflux ensures the complete and targeted treatment of varicose veins.

Lim A. Duplex Ultrasound for Varicose Veins. *Opin Prog Cosmet Dermatol.* 2025;5(1):18.

PROCEDURAL CLIP

Endovenous Laser Ablation of Varicose Veins



PRESENTED BY
Dr Adrian Lim

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PROCEDURAL OVERVIEW

Key concepts

- Endovenous laser ablation (EVLA) is a minimally invasive thermal technique for treating incompetent saphenous veins.
- Thermal energy causes irreversible endothelial damage, vein wall shrinkage, and fibrosis.
- EVLA replaces traditional surgical stripping, with fewer complications and quicker recovery.

Procedural techniques

- **Access and catheterisation:** Ultrasound-guided insertion of a fibreoptic laser catheter into the great saphenous vein, usually from the knee to the groin.
- **Tumescent anaesthesia:** Longitudinal infiltration along the vein in the subfascial plane to provide local anaesthesia, compress the vein, and protect surrounding tissue.
- **Laser activation:** Controlled delivery of thermal energy during slow catheter pullback, inducing vein closure.

Post-procedure care

- Compression bandaging or stockings applied immediately.
- Early ambulation encouraged.
- Follow-up ultrasound to confirm closure and rule out deep vein thrombosis.

Adjunctive ultrasound-guided foam sclerotherapy (UGFS)

- UGFS targets residual reflux in the truncal or tributary veins after EVLA.
- Compression stockings and daily walking prevent thrombosis and enhance treatment outcomes.

Lim A. Endovenous Laser Ablation of Varicose Veins. *Opin Prog Cosmet Dermatol.* 2025;5(1):19.

PROCEDURAL CLIP

Cyanoacrylate (Glue) Closure of Varicose Veins and Perforators

PRESENTED BY
Dr Adrian Lim

CLICK ON IMAGE TO WATCH VIDEO DURATION_01:36

PROCEDURAL OVERVIEW

Key concepts

- Cyanoacrylate closure is a non-thermal, non-tumescent technique for closing incompetent veins using medical-grade cyanoacrylate adhesive (e.g., VenaBlock).
- It is effective for both proximal truncal veins (e.g., the great saphenous vein [GSV]) and refluxing perforators.
- The adhesive polymerises on contact with blood, causing vein wall adhesion and fibrosis.

Procedural techniques

Proximal GSV closure

- A soft catheter is introduced into the proximal GSV (knee to groin).
- As the catheter is slowly withdrawn, cyanoacrylate is injected.
- Polymerisation causes thermal bonding of the vein walls.
- External compression is applied for optimal closure.
- Typical volume: approximately 2 mL of VenaBlock.
- Point injection may be used as an alternative technique.

Perforator closure

- Under ultrasound guidance, small volumes (0.1–0.3 mL) of glue are point-injected near the perforator opening.
- Post-injection compression and ambulation enhance treatment success.

Possible complications

- Phlebitis.
- Foreign body reaction.
- Granuloma formation.
- Rare: Glue embolisation (can be minimised with proper technique).

Lim A. Cyanoacrylate (Glue) Closure of Varicose Veins and Perforators. *Opin Prog Cosmet Dermatol*. 2025;5(1):20.

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