

A comparison of triple combination cream and hydroquinone 4% cream for the treatment of moderate to severe facial melasma

Tania Ferreira Cestari, MD,¹ Karime Hassun, MD,² Alexandre Sittart, MD,³ & Maria de Lourdes Viegas, MD⁴

¹Department of Dermatology, Federal University of Rio Grande do Sul – Hospital de Clinicas de Porto Alegre, Porto Alegre, Brazil

²Department of Dermatology, Federal University of São Paulo, São Paulo, Brazil

³Hospital do Servidor Público Estadual, São Paulo, Brazil

⁴Hospital da Lagoa, Rio de Janeiro, Brazil

Summary

The aim of this study was to compare the efficacy and safety of a triple combination (TC) cream and monotherapy with hydroquinone (HQ) cream in the treatment of moderate to severe facial melasma. A total of 120 patients **applied TC cream once daily or HQ cream twice daily for 8 weeks**. Evaluations included static global severity assessment of melasma, improvement of melasma over time, local tolerability, and adverse events. TC cream was significantly more effective than HQ cream from week 4 onwards: lesions were approximately equivalent to the surrounding skin in 35% of all TC-treated patients, compared to 5% of those who used HQ cream ($P = 0.0001$). Improvement of more than 75% was achieved by 73% of TC cream patients and 49% of HQ cream patients ($P = 0.007$). The incidence of adverse events (erythema, burning sensation, and desquamation) was similar in both groups. No patient dropped out of the study because of drug-related adverse events. TC cream was more effective than the HQ cream for the treatment of moderate to severe facial melasma. Both products had similar safety profiles.

Keywords: facial melasma, fluocinolone acetonide, hydroquinone, stable fixed combination, topical therapy, tretinoin

Introduction

Cutaneous melasma is a common dermatologic disease, occurring in all races, but more commonly in Asian and Hispanic women with dark skin and of child-bearing age.^{1–5}

Many factors have been implicated in the pathogenesis of melasma; however, the most important ones remain

ultraviolet (UV) radiation, hereditary predisposition, and hormonal dysfunction.^{2,3}

Therapy for melasma remains a challenge and topical treatments are the mainstay.^{2,6,7} Current approaches to the management of melasma include hydroquinone (HQ), considered the gold standard depigmenting agent, and other molecules such as azelaic acid, tretinoin (RA), alpha and beta hydroxy acids, and topical corticosteroids used as monotherapy or in various combinations.^{7–15} A shortcoming of monotherapy has been the length of treatment required to experience significant results. A classic study conducted by **Kligman and Willis** showed no substantial improvement in pigmentation after 3 months of treatment with HQ, dexamethasone, or RA alone. However, they did observe satisfactory results when the substances were used as combination of **0.1% RA, 5.0%**

The authors received payments for the recruitment of subjects for this clinical trial. None of the authors has any financial interest in Galderma Laboratories to disclose.

Correspondence: Tania Cestari, MD, Rua Mostardeiro 333, conjunto 415, Moinhos de Vento, CEP 90430-001, Porto Alegre/RS, Brazil.
E-mail: tcestari@hcpa.ufrgs.br

Accepted for publication May 29, 2006

HQ, and 0.1% dexamethasone in a hydrophilic ointment.¹⁵ Furthermore, other experimental and clinical studies showed that the use of retinoids prevents the epidermal atrophy that may occur with topical corticosteroids.^{16,17} This may be a result of the ability of retinoids to induce hyperplasia of epidermal cells as well as dermal collagen synthesis.^{16,17}

Recently, a stable fixed combination therapy was developed containing HQ 4%, RA 0.05%, and fluocinolone acetonide (FA) 0.01%, a low potency (Class VI American classification) corticosteroid.¹⁸ This formula is currently marketed under the trade name Tri-Luma® Cream (Galderma Laboratories L.P.), hereafter called triple combination (TC).

The aim of the present study was to compare the clinical efficacy and safety of TC cream with that of 4% HQ in patients with moderate to severe facial melasma.

Materials and methods

This study was a randomized, controlled, open-label clinical trial conducted in 120 patients from four hospitals in Brazil. It was conducted in accordance with the principles of the Declaration of Helsinki and its amendments, and in compliance with local regulatory requirements. Patients provided their written informed consent prior to study procedures and were at least 18 years of age, of either gender, with moderate to severe facial melasma. Pregnant women or patients with specific exclusion criteria were not allowed to participate in the study. Specific washout periods for previous treatments were to be respected.

Eligible patients were randomized to receive one of the two treatments as follows: TC cream (HQ 4%, RA 0.05%, and fluocinolone acetonide 0.01%) once daily or HQ cream (HQ 4%; Claripel™, Stiefel Laboratories Inc., Miami, FL, USA) twice daily. Both treatments were applied to the affected facial areas for 8 weeks. Study visits were held at weeks 0, 2, 4, 6, and 8. Subjects from both groups received sunscreen (SPF 30) and were instructed to apply on the face at least once a day.

The primary efficacy variable was the investigator's static evaluation of melasma severity at each visit using the following scale: 0 = melasma lesions very similar to the surrounding normal skin or with minimal residual hyperpigmentation; 1 = mild (slightly darker than the surrounding normal skin); 2 = moderate (moderately darker than the surrounding normal skin); and 3 = severe (markedly darker than the surrounding normal skin). "Primary success" was defined as a melasma severity score of 0 at week 8.

The secondary efficacy variables were evaluations of the overall improvement by the investigator and by the subject. Evaluation of overall improvement by the investigator was performed at each visit using a scale from 5 (completely cleared [100%]) to -1 (worsening, hyperpigmentation darker than that of baseline melasma). "Secondary success" was defined as an improvement score between 3 and 5. Overall evaluation by the subject was performed at week 8 using a scale from 1 (excellent) to 4 (poor).

Tolerability was evaluated at each visit by assessing the incidence of expected adverse events (i.e., skin atrophy, telangiectasia, or erythema). All other adverse events occurring during the study were also recorded.

The statistical analysis of this non-inferiority study was performed on the per-protocol population consisting of all patients who received study medication throughout the study and who had all melasma assessments done. The following statistical tests were used: Student's *t*-test for the comparison of age between groups; one-sided analysis of variance for the comparison of treatment duration among the four centers; chi-squared test for the comparison of sex, race, phototype, and patient's overall evaluation; Fisher's exact test for the comparison of primary success, secondary success, and adverse events between groups; the Friedman's test for the comparison of melasma severity, overall improvement, and total number of symptoms within each group; and the Mann-Whitney test for the comparison of melasma severity, overall improvement, and total number of symptoms between the study groups. Two-sided tests were used and the significance level was 5%.

Results

A total of 120 patients were enrolled in the study: 60 were treated with TC cream and 60 received HQ cream. A total of 119 patients completed the 8-week study; one subject in the HQ group discontinued at week 6 due to a non-drug-related adverse event. Table 1 depicts the demographic data.

At baseline, more than 98% of all subjects in both groups had moderate (grade 2) or severe (grade 3) melasma according to the investigator's static evaluation of melasma severity. At weeks 4, 6, and 8, melasma severity scores were significantly lower in the TC cream group than in the HQ cream group ($P < 0.003$). Figure 1 shows the percentage of patients with cleared melasma at all time points. "Primary success," defined as melasma lesion approximately equivalent to the surrounding normal skin, was achieved for 35% (21/60) of patients in the TC group and for 5.1% (3/59) of subjects in the HQ cream group ($P = 0.0001$).

Furthermore, the results of the present study are in accordance with findings made in another 8-week study showing that TC cream was significantly more effective in achieving total clearing of melasma than any of its dyads (i.e., dual combinations: HQ + RA, HQ + EA, or EA + RA).¹⁸

Some authors have expressed concerns regarding the risk of telangiectasia and skin atrophy following long-term topical administration of corticosteroids.⁷ A total of 14 cases of telangiectasia were reported at the end of treatment: nine patients (15%) treated with TC cream relative to five patients (9%) treated with HQ cream. The incidence of this adverse event is possibly related to the fact that certain patients applied the studied drugs to the whole face, hence exposing a greater surface and is not related to the treatment of melasma using the medications. However, none of these events resulted in the discontinuation of the study. Previous clinical long-term investigations confirmed that the incidence of telangiectasia with TC cream did not exceed 4% of the total study population.¹⁹

The absence of skin atrophy with TC cream may be related to the presence of RA, preventing corticosteroid-induced atrophy without lessening the anti-inflammatory effect, as proposed by Kligman *et al.* and McMichael *et al.*^{16,17} Furthermore, the relatively low incidence of side effects commonly associated with corticosteroids may be due to the fact that fluocinolone acetonide in a concentration of 0.01% is a medium to low potency (Class VI) corticosteroid.

Local adverse events, such as erythema, burning sensation, and desquamation, were equally distributed in both groups.

In conclusion, an 8-week treatment with a once-a-day application of TC cream was shown to be significantly more effective (73% vs. 49%) than a twice-a-day application of HQ in the treatment of moderate to severe facial melasma, while showing similar and good safety profiles.

Acknowledgments

The authors would like to thank Helen Baldwin and Patrick Göritz, Galderma R&D, for their assistance in writing this article.

This article received an educational grant from Galderma Laboratories, Brazil.

References

- Grimes PE. Melasma: etiologic and therapeutic considerations. *Arch Dermatol* 1995; **131**: 1453–7.
- Mosher DB, Fitzpatrick TB, Ortonne J-P, Hori Y. Hypomelanoses and hypermelanoses. In: IM Freedberg, AZ Eisen, K Wolff *et al.*, eds. *Fitzpatrick's Dermatology in General Medicine*, Vol. 1. New York: McGraw-Hill; 1999: 945–1017.
- Barankin B, Silver SG, Carruthers A. The skin in pregnancy. *J Cut Med Surg* 2002; **6**: 236–40.
- Sober AF, Fitzpatrick TB. Disturbances of pigmentation. Section I. Mechanisms of pigmentation in man. In: SL Moschella, DM Pillsbury, HJ Hurley Jr, eds. *Dermatology*, Vol. 2. Philadelphia: W.B. Saunders Co; 1975: 1085.
- Vasquez M, Maldonado H, Benmaman C, Sanchez JL. Melasma in men. *Int J Dermatol* 1988; **27**: 25–7.
- Pathak MA, Fitzpatrick TB, Kraus EW. Usefulness of retinoic acid in the treatment of melasma. *J Am Acad Dermatol* 1986; **15**: 894–9.
- Giannotti B, Melli MC. Current approaches to the treatment of melasma. *Clin Drug Invest* 1995; **0** (Suppl. 2): 57–64.
- Griffiths CEM, Finkel LJ, Ditre CM *et al.* Topical tretinoin (retinoic acid) improves melasma. A vehicle-controlled, clinical trial. *Br J Dermatol* 1993; **129**: 415–21.
- Verallo-Rowell VM, Veralló V, Graupe K *et al.* Double-blind comparison of azelaic acid and hydroquinone in the treatment of melasma. *Acta Derm Venereol* 1989; **143** (Suppl.): 58–61.
- Sanchez JL, Vazquez M. A hydroquinone solution in the treatment of melasma. *Int J Dermatol* 1982; **20**: 55–8.
- Kimbrough-Green CK, Griffiths CEM, Finkel LJ *et al.* Topical retinoic acid (tretinoin) for melasma in black patients. *Arch Dermatol* 1994; **130**: 727–33.
- Gano SE, Garcia RL. Topical tretinoin, hydroquinone, and betamethasone valerate in the therapy of melasma. *Cutis* 1979; **23**: 239–41.
- Kang WH, Chun SC, Lee S. Intermittent therapy for melasma in Asian patients with combined topical agents (retinoic acid, hydroquinone and hydrocortisone): clinical and histological studies. *J Dermatol* 1998; **25**: 587–96.
- Katsambas A, Antoniou Ch. Melasma: classification and treatment. *J Eur Acad Dermatol Venereol* 1995; **4**: 217–23.
- Kligman AM, Willis I. A new formula for depigmenting human skin. *Arch Dermatol* 1975; **111**: 40–8.
- Kligman LH, Schwartz E, Lesnik RH, Mezick JA. Topical tretinoin prevents corticosteroid-induced atrophy without lessening the anti-inflammatory effect. *Curr Probl Dermatol* 1993; **21**: 79–88.
- McMichael AJ, Griffiths CE, Talwar HS *et al.* Concurrent application of tretinoin (retinoic acid) partially protects against corticosteroid-induced epidermal atrophy. *Br J Dermatol* 1996; **135**: 60–4.
- Taylor S, Torok H, Jones T *et al.* Efficacy and safety of a new triple combination agent for the treatment of facial melasma. *Cutis* 2003; **72**: 67–72.
- Torok H, Taylor S, Baumann LM *et al.* A large 12-month extension study of an 8-week trial to evaluate the safety and efficacy of triple combination (TC) cream in melasma patients previously treated with TC cream or one of its dyads. *J Drugs Dermatol* 2005; **4**: 592–7.