



Peels & Resurfacing

ROLES WITHIN THE PHYSICIAN
AND NON-PHYSICIAN SETTING

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dermatology

Peels have been a treatment staple in the medical aesthetic office for decades as physicians have utilized them effectively for anti-aging and acne. Time has changed this model of practice some, since the advent of lasers and the addition of aesthetic professionals to offices. The employ of these professionals, such as estheticians, nurses and physician assistants, by a physician expands his practice. The physician can be performing 'physician-only' treatments, such as deep peels, lasers, and more, while his staff is performing treatments legal for them to perform in their state.

To understand peels in this setting, one must understand what the word means. For years, the word 'peel' was used loosely in the aesthetic industry, meaning anything from enzymes to TCA was called a 'peel.' Then, the Cosmetic Ingredient Review

board (CIR) published its findings on glycolic in 1996, with recommendations to change this misnomer. The CIR is an independent body which thoroughly reviews and assesses the safety of ingredients used in cosmetics in an open, unbiased, and expert manner and publishes the results in open, peer-reviewed scientific literature. Many states have adopted these recommendations into their regulatory system, clearing up many of the misunderstandings.

To understand these recommendations, one must first understand the terms 'aesthetic level,' 'physician level' and 'physician only' for products and treatments. Aesthetic level products can be used by licensed estheticians in a non-medical setting, meaning there is no physician on staff,

while aesthetic level treatments are performed by licensed estheticians, and in most states, even by cosmetologists. These treatments can also be performed and the products used in a medical setting. Physician

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level treatments, however, must be used in a physician-supported setting. A physician is responsible for the safe performance of the treatments and safe use of the products. In many states, the physician is also responsible for the training of the persons performing these treatments.

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CIR Recommendations

The actual subject which produced the CIR recommendations was the safety of glycolic, resulting in recommendations concerning the use of glycolic and other products in the skin care room. The typical regulations in the 'CIR states' are as follows:

Aesthetic level alpha hydroxy acids are required to be 30% and below and 3.0 pH or above. These are not to be called 'peels' as they are considered resurfacing or exfoliation. Physician level acid percentages and pH are at the discretion of the physician.

Aesthetic level salicylic acid must be 20% or below, and 3.0 pH or above. The physician level is at the physician's discretion, but is usually 30%, with a lower pH.

Every exfoliation or peel treatment must include the recommendation of a sun protection product by the professional.

In reality, these states have removed the use of higher acids in the aesthetic skin care rooms which do not have medical support, unless specifically mentioned in the regulation. For example, Colorado allows the use of a Jessners at the aesthetic level, but it cannot be over 14% lactic acid, 14% salicylic acid and 14% glycolic. Many states also restrict the number of layers at 1-4 at the aesthetic level.

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Many states have removed the use of the word 'peels' from the menus of services in aesthetic level facilities, encouraging the use of the

of a non-physician-supported facility. There are legitimate reasons for these title replacements. These percentages of acids, if properly performed, do not necrotize the epidermis; instead, they increase the turnover of cells in the

epidermis, allowing a speedier release of dead cells to reveal the younger, more youthful cells, and allowing a more youthful appearance. No peeling is caused by these products, if properly performed.

Peels, conversely, do cause

partial or full peeling of the epidermis or of the epidermis and dermis. The cells to the depth of the peel are necrotized and literally peel from the

words 'exfoliation' or 'resurfacing.' In Ohio, for example, this is termed 'resurfacing,' not peeling, and the word 'peel' is not allowed in the menu

surface of the face during the stages of healing.

AESTHETIC RESURFACING AND ITS ROLE

Aesthetic resurfacing has a legitimate role in the physician's office as well as in the non-physician-supported aesthetic room. First, many patients do not need the removal of their epidermis or the epidermis and dermis for rejuvenation. Their exfoliation merely needs to be stimulated, and the dermal layer reorganized. This person will respond well to the 30% resurfacing with younger, more plump and glowing skin.

Second, many patients do not have the time for nor the desire to go through the down time which a serious peel requires. Many of these patients will be good candidates for a resurfacing series, bypassing the down time.

Resurfacing treatments are usually performed in a series, at least six as the rejuvenation does not become apparent until after at least three treatments. In rejuvenation, the time between the treatment should be two weeks to allow maximized reorganization of the dermal matrix between treatments. In acne salicylic acid series, the time between the applications can be one week, as reorganization of the dermis is not the goal; instead, it is the follicular treatment.

The series can be a goal in itself for achieving results, or can be the pre-treatment preparation of the skin to maximize another treatment, such as a laser treatment or peel. An example would be a glycolic series performed before a laser treatment.

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PHYSICIAN LEVEL PEELS

'Physician level peels' are those which must be performed in a physician-supported facility. These peels can, if desired, go below the epithelial-dermal junction into the dermis with a peeling result. Examples are 10-25% TCA (trichloroacetic acid) peel and Jessners.

Mark G. Rubin, M.D., author of *Manual of Chemical Peels* (Lippincott Williams and Wilkins, Philadelphia, PA), describes peels by 'the depth of penetration or the histological boundaries of the necrosis (cellular dissolution) induced.' According to his description, a 'very superficial peel' will thin or remove the stratum corneum but nothing below. There is no wounding. A 'superficial peel' produces destruction, or necrosis, of part or all of the epidermis to the basal layer. The 'medium peel' necrotizes the entire epidermis into part or all of the papillary dermis. A 'deep peel' causes necrosis of the epidermis and papillary dermis, possibly into the mid-reticular dermis. Noting this definition of peels, it is evident that peels beyond the 'very superficial peel' are out of the scope of practice for estheticians unless they are under a physician's supervision.

Deep peels, considered physician-only treatments, are performed by a physician only due to their depth of wound. Due to their depth, they create a greater risk of complications and a longer recovery. In reality, most physicians are moving to their lasers for the goals of these treatments. Examples of these peels are TCA 25%-35% and Phenol. The latter is rarely used today due to high potential for toxicities and scarring.

FITZPATRICK CLASSIFICATION SYSTEM

Skin Type	Skin Color	Characteristics
I	White	Always burns, never tans Blue eyes, blond or redhead
II	White	Usually burns, sometimes tans Light skin and hair
III	White	Sometimes burns, tans Medium complexion, varied hair color
IV	Olive	Rarely burns, tans well Darker skin, brown eyes
V	Brown	Rarely burns, tans deeply Brown skin, brown eyes
VI	Black	Never burns, deeply pigmented Black skin, brown eyes

ADVANTAGES AND DISADVANTAGES OF PEELS

Dr. Rubin describes a peeling agent as a chemical which can cause some form of peeling after one application. Peels are more intense than resurfacing due to the necrotizing of the epidermis and sometimes the dermis, and the re-establishment of healthier, evenly restructured epidermis and potentially the dermis. The advantages of peels are the improvement of color, freshness, texture, skin tone, and the treatment of fine or medium-depth wrinkles, as defined by the depth of the peel, and hyperpigmentation.

The disadvantages of peels are the exaggerated expectations of clients, compounded by the need for responsible decisions by trained technicians in both the execution of the peels and the need for training in the selection of candidates and in application of the products. The

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expectations can be dealt with through patient communication, even through a brochure which addresses this education. Choice of treatment and application education can only be addressed through formal education of the professionals.

The American Mix

The Fitzpatrick Classification System is an excellent tool for choosing the correct resurfacers and peels, but it is not 'foolproof' due to the mixture of ethnicities in our melting pot nation. The professional, however, can bypass this complication by asking questions. Appropriate questions would be:

- Do you tan easily? Always? How often?
- Do you burn easily? Always? How often?
- Have you had a resurfacing or peel before?
- How did your skin respond?
- What acid was used? Do you know the percentage?

Always know that a client fully understands the potentials for erythema and hyperpigmentation and his or her role in preventing these conditions. Gain full compliance to pre-, in-, and post-series care prior to performing any treatment, get a signature of understanding, and offer written support to the information.

ASKING THE RIGHT QUESTIONS

The Fitzpatrick Classification System, a classifier for skin and its tendency to hyperpigmentation and erythema (redness) from exposure to the sun, is utilized in estimating how susceptible skin is to erythema with acid applications and in defining which clients will have a high risk for hyperpigmentation. The client is asked questions concerning his or her tendency to become red or tan after exposure to the sun. The original Fitzpatrick Scale follows:

When considering a peel, the erythema tendency is higher on the Fitz I and II patients, meaning they may respond with more erythema than the III, IV, V, and VI. Peels must be performed with care on these clients, with fewer layers and a great deal of preconditioning, including melanocyte suppressants. Pre-series conditioning of the skin is very important in preventing or lessening erythemic responses for resurfacing and peels, keeping in mind that erythema triggers melanocyte activity and, therefore, hyperpigmentation. Erythema also causes discomfort for the client, a longer healing process, and possibly even scarring. The key here is education, safety, and vigilance in performing the treatment.

The pigmentation aspect of the Fitzpatrick scale suggests that as a general rule Types IV, V, and VI will have a significantly higher risk of responding with post-inflammatory hyperpigmentation through even minor inflammation. The policy on using peels is controversial for these Fitzpatrick types, with many practitioners saying that peels of any



kind are no-nos for their skin. If the practitioner does perform peels on these skin types, due to his or her philosophy of care, long and intense pre-conditioning is absolutely necessary with melanocyte suppressants in the pre-care for at least one month and continuing in post-care.

Pre-conditioning of the skin is a must for acid and peel clients, as is in-series and post treatment care. Pre-conditioning includes care which will bring the skin to maximum health prior to the treatments, whether resurfacing or peel, and to suppress melanocyte activity. Pre-conditioning will control erythema and minimize hyperpigmentation, a wise pre-care technique for practitioners. For a full discussion of this topic, see volume 4, issue 3, may/june 2005 issue of *Aesthetic Trends and Technologies*.

THE BUSINESS OF RESURFACING AND PEELS

Resurfacing and peels are staples of the new aesthetic industry and are

treatments which bring a large number of patients into every practice or medical spa. A wise practitioner will market these treatments to his or her patients and the community through many channels such as direct mail, 'column' advertorials in the local papers, participation in community affairs, and many other channels. Many marketing companies specialize in this type of program for medical aesthetic practices and medical spas, and dramatic growth for the business can be noted quickly with this type marketing. If there is interest in this type marketing, ask around among those who are successful for a company which has worked the magic for them.

USE-AS-DIRECTED

The FDA continues to hear complaints of damage due to treatment professionals, estheticians, physicians assistants, and physicians who use products in ways that the product's percentage, pH, or chemistry are not designed to be used. They go over the line, making

THE GENERALLY ACCEPTED RESURFACERS ARE:

- 20% and 30% Lactic Acid
- 30% Glycolic Acid
- 20% Salicylic Acid
- 10% TCA

THE GENERALLY ACCEPTED PEELS ARE:

- 40% - 50% - 70% Glycolic Acid
- 30% Salicylic Acid
- Jessners
- Modified Jessners
- 20%-35% TCA

poor judgments, not following directions, pushing the envelope of results, or just plain being careless. Patients are harmed, even scarred by these hot doggers, and many times law suits follow. Obviously, these overconfident people are the

bane to the aesthetic industry as well as to the patients.

As a biochemist, I believe these persons are also the bane to my business and to that of other formulators, in this sue-happy society in which we live. For that reason, many formulators are asking for the responsible party in the spa or practice to sign an agreement which they understand and will use the products as recommended, according to proven-safe protocols. These agreements put the responsibility on the proper person when the products are used by overly aggressive and improper protocols.

Resurfacing and peels are a continuing staple in the aesthetic community and, used properly, can be the source of high income and growth in the facilities where they are used. ❗

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