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## A Review of the Biologic Effects, Clinical Efficacy, and Safety of Silicone Elastomer Sheeting for Hypertrophic and Keloid Scar Treatment and Management

BRIAN BERMAN, MD, PHD,\* OLIVER A. PEREZ, MD,\* SAILESH KONDA, BS,\* BRUCE E. KOHUT, DMD,†  
MARTHA H. VIERA, MD,\* SUZETTE DELGADO, BS,\* DEBORAH ZELL, MD,\* AND QING LI, MD, PHD†

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Silicone elastomer sheeting is a medical device used to prevent the development of and improve the appearance and feel of hypertrophic and keloid scars. The precise mechanism of action of silicone elastomer sheeting has not been defined, but clinical trials report that this device is safe and effective for the treatment and prevention of hypertrophic and keloid scars if worn over the scar for 12 to 24 hours per day for at least 2 to 3 months. Some of the silicone elastomer sheeting products currently on the market are durable and adhere well to the skin. These products are an attractive treatment option because of their ease of use and low risk of adverse effects compared to other treatments, such as surgical excision, intralesional corticosteroid injections, pressure therapy, radiation, laser treatment, and cryotherapy. Additional controlled clinical trials with large patient populations may provide further evidence for the efficacy of silicone elastomer sheeting in the treatment and prevention of hypertrophic and keloid scars. The purpose of this article is to review the literature on silicone elastomer sheeting products and to discuss their clinical application in the treatment and prevention of hypertrophic and keloid scars.

*Bruce Kohut and Qing Li are employees of Pfizer, Inc., which markets the Neosporin Scar Solution.*

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**H**ypertrophic and keloid scars are abnormal scars that develop after wound healing in some individuals. A keloid is characterized by an overgrowth of scar tissue beyond the borders of the original wound. Hypertrophic scars consist of an abundance of scar tissue confined to the original wound site.<sup>1</sup> The development of hypertrophic scars and/or keloids after an injury may be especially problematic for patients because the unsightly scar may restrict range of motion, cause symptoms of pruritus and pain, and serve as a constant visible reminder of the trauma endured in the past.<sup>2-5</sup> Although the etiology of hypertrophic and keloid scars is unclear, they occur only in humans and are more common in dark-skinned individuals, patients younger than 30 years of age, and those with atopic symptoms.<sup>6,7</sup> An association with hormone levels

has also been noted. Keloids often occur during puberty, worsen during pregnancy, and improve after menopause.<sup>7</sup> Although hypertrophic and keloid scars may serve as body art in some cultures,<sup>8</sup> most patients desire to minimize the appearance of such scars. Several treatment and prevention modalities exist, such as surgical excision, radiation, laser treatment, pressure therapy, intralesional corticosteroid injections, cryotherapy, application of silicone products, and various topical and oral medications.<sup>9</sup> Silicone has been proposed as the main form of noninvasive treatment for hypertrophic and keloid scars and has demonstrated significant improvements in scar elasticity in patients prone to abnormal scarring.<sup>10-12</sup> More than 60 silicone elastomer products have been marketed since 1990.<sup>13</sup> This review will focus on the treatment and prevention of

\*Department of Dermatology and Cutaneous Surgery, University of Miami, Miller School of Medicine, Miami, Florida; †Global Medical Affairs & Clinical Research, Pfizer Consumer Healthcare, Pfizer, Inc., Morris Plains, New Jersey

hypertrophic and keloid scars with silicone elastomer sheeting, a medical device that is used to soften, flatten, and blanch hypertrophic and keloid scars to produce a more aesthetically acceptable scar and increase range of motion by improving scar elasticity. In addition, silicone elastomer sheeting has been shown to reduce symptoms of pruritus and pain associated with hypertrophic and keloid scars.<sup>14,15</sup>

**Properties of Silicone Elastomer Sheeting**

Many prescription and over-the-counter silicone products are available for the treatment and prevention of hypertrophic and keloid scars (Table 1). The information presented in this review article has been compiled by searching the United States Food and Drug Administration (FDA) Center for Devices and Radiological Health 510(k) Premarket Notification Database, using the search term “MDA,” which is the product code for silicone elastomer products for scar management. After nonsilicone products and duplicate entries were deleted, more than 60 products remained.<sup>13</sup> The differences among the products generally lie in their physical characteristics. Available products include silicone elastomer sheeting with and without a fabric backing, polyurethane foam, pressure garments, splints, fabric bandages that have one surface coated with silicone gel, silicone gels, ointments, sprays that dry to form a thin coat of silicone over the skin surface, and silicone liquid and strips enhanced with vitamin E and/or steroids.<sup>16-37</sup>

Silicone elastomer sheeting products used for the treatment and prevention of hypertrophic and keloid scars have similar chemical features. The element

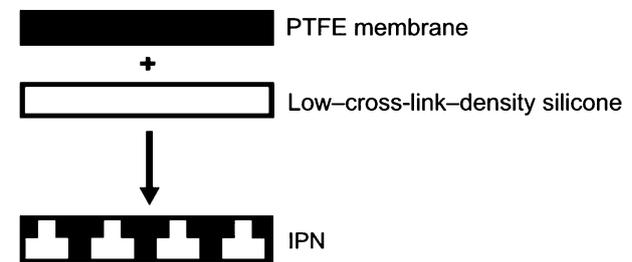
silicon bonds with oxygen, forming a siloxane molecule. Repeating siloxane units form polysiloxanes, to which methyl groups may attach. The resulting molecules, polydimethylsiloxanes, are also known as silicone polymers and may be cross-linked to form gels and elastomers. A high degree of cross-linking yields a rubbery, solid elastomer. Conversely, less extensive cross-linking creates a silicone gel. As the degree of cross-linking increases, the silicone becomes more durable, but less adherent.<sup>38</sup> To maximize the durability and adhesiveness of silicone elastomer sheeting, some products combine a silicone elastomer that has a relatively low degree of cross-linking with an expanded polytetrafluoroethylene membrane to create an interpenetrating polymer network (IPN; Figure 1). The IPN has greater durability than the silicone elastomer alone but still retains good adhesion to the skin.<sup>39</sup>

**Proposed Mechanisms of Action**

Knowledge of the physical features of silicone elastomer sheeting may aid in understanding its mechanism of action. There are several hypotheses that try to explain the efficacy of silicone sheeting in treating hypertrophic and keloid scars; several studies have gathered evidence supporting or refuting each, but no distinct mechanism has been defined. Possible mechanisms include increased temperature,<sup>40</sup> hydration caused by occlusion of the underlying skin,<sup>41-46</sup> increased oxygen tension,<sup>47</sup> direct action of the silicone oil,<sup>44</sup> and polarization of the

**TABLE 1. Types of Silicone Products Available for Scar Prevention and/or Therapy<sup>13</sup>**

Product type	Number of available products
Silicone elastomer sheet	43
Silicone gel	11
Silicone-filled cushion	2
Foam with silicone interface	3
Silicone spray	1



**Figure 1.** Low-cross-link-density silicone is cross-linked through a polytetrafluoroethylene (PTFE) membrane, resulting in an interpenetrating polymer network (IPN), which has greater physical strength and durability than the low-cross-link-density silicone elastomer alone and retains its adhesive properties.<sup>39</sup>

scar tissue caused by the negative static electric charge generated by movement of the silicone.<sup>48</sup> Silicone sheeting may also correct aberrant immunologic processes, which if left unchecked, may alter the tissue repair process and ultimately result in the formation of hypertrophic and keloid scars.<sup>15,49,50</sup>

*Increased Temperature* The surface temperature of 18 hypertrophic scars has been shown to increase from 29 to 30.7°C ( $p = .001$ ) in 16 patients treated with silicone gel sheeting. Since slight increases in temperature can increase collagenase activity,<sup>51</sup> it has been hypothesized that silicone gel sheeting improves hypertrophic and keloid scars by increasing the breakdown of collagen by the collagenases through an increase in skin temperature.<sup>40,52,53</sup>

*Hydration Effects* Many investigators have studied the hydration effects of silicone elastomer sheeting on the stratum corneum.<sup>41-46</sup> Quinn and colleagues<sup>44</sup> have observed that, when applied to a scar, the treated skin area loses water via evaporation at a rate of half that of the untreated skin area. After removal of the silicone gel, the water loss from the underlying treated skin area increases significantly for a period of 15 to 20 minutes. Because fluid has not been seen or felt on the scar or silicone gel, these researchers have postulated that the stratum corneum can act as a water reservoir.<sup>44</sup> In a separate study, Sawada and Sone<sup>54</sup> have also suggested that occlusion and hydration are the principal modes of action of a silicone cream/occlusive dressing. It should be noted, however, that this hydration effect has also been obtained with creams and dressings without silicone.<sup>55-56</sup> Chang and colleagues<sup>42</sup> further elucidated this mechanism by examining the cellular effects of silicone and hydration with an in vitro keratinocyte-fibroblast culture model. The proliferation of fibroblasts and their collagen and glycosaminoglycan production was inhibited in the hydration-treated group with no apparent change in fibroblast activity in the silicone-treated group.

The clinical efficacy of increased hydration for flattening and blanching of hypertrophic and keloid scars and improvement of pruritus, pain, and

edema was assessed by comparing the effects of a hydrating cream with a hydrating dressing in 20 patients. During a treatment period of 2 months, the researchers found a significant reduction in itching ( $p < .03$ ) and reduced pain ( $p < .08$ ), as well as increased pliability (10%) associated with both treatments. These results suggest that hydration of a scar over a prolonged period can improve the above symptoms.<sup>43</sup> As a possible explanation for this phenomenon, Beranek<sup>57</sup> proposed that hydration of a scar decreases capillary activity and thus local collagen deposition.

Preliminary laboratory studies have shown that silicone elastomer sheets have high oxygen permeability.<sup>47</sup> This observation has led to the hypothesis that the mechanism of action of silicone elastomer sheeting is twofold: (1) Silicone elastomer sheets increase hydration and oxygen tension in the stratum corneum by limiting the escape of moisture while allowing oxygen access to the skin surface, which is in turn more permeable to oxygen when hydrated. (2) Oxygen tension is believed to be important in scar improvement because angiogenesis and tissue growth are stimulated in response to tissue hypoxia in a healing wound.<sup>47,58</sup>

Not all researchers agree that silicone elastomer sheeting increases skin hydration. One study compared the hydration effects of silicone gel sheeting with plastic film over 7 days on the stratum corneum. Measured hydration was significantly less in the skin occluded with silicone gel sheeting than skin occluded with plastic film ( $p < .005$ ). After 7 days, hydration in skin covered with silicone gel sheeting was significantly less than that on the first day of the study ( $p < .005$ ), suggesting that the hydrating effect of silicone gel sheeting decreases with repetitive daily treatment. These results do not support the hypothesis that silicone gel sheeting causes hypertrophic scar and keloid shrinkage via a hydrating effect.<sup>46</sup>

*Direct Action of Silicone Oil* Quinn and colleagues<sup>44</sup> noted that silicone gel sheeting created an oily im-

print on filter paper after being in contact with it for 6 hours and hypothesized that this silicone oil, along with hydration, is responsible for the mechanism of action of silicone gel sheeting. In an *in vivo* study comparing silicone gel sheets to polyurethane membranes applied to healthy skin, the presence of silicone was detected in the stratum corneum of skin exposed to silicone gel sheets using Fourier transform infrared attenuated total reflectance spectroscopy. The researchers found the concentration of silicone in the stratum corneum decreased with depth, indicating that the silicone probably did not reach the underlying viable layers of skin.<sup>41</sup> Shigeki and colleagues<sup>59</sup> also demonstrated the *in vitro* release of silicone-related compounds from a silicone gel sheet and their water-soluble distribution into the skin. Other researchers have not detected the presence of silicone in skin that had been treated with silicone gel sheeting.<sup>14,60</sup>

**Polarized Electric Charge** Results from several trials suggest that a negative charge within a silicone cushion causes polarization of the scar tissue and leads to scar shrinkage.<sup>48,61–63</sup> Application of a silicone oil-filled cushion to hypertrophic and keloid scars in 30 patients resulted in flattening and blanching of the scars and improvement of symptoms in 63.3% of patients within 6 months. Twelve patients showed scar improvement within 2 to 3 weeks, and 24% of patients exhibited scar resolution within 12 months. Improvement in scar appearance in patients treated with silicone gel sheeting requires treatment for several months. The researchers attribute the rapid improvement of some patients to the presence of a negative static electric charge generated by the silicone cushion. Such a charge is unique to the silicone cushion because of the dynamic movement of the silicone oil contained within the cushion. In contrast, any charge present on silicone gel sheeting dissipates once humidity increases under the sheet. A follow-up study by Berman and Flores<sup>64</sup> found both silicone gel cushion and silicone gel sheeting to be effective in the treatment of scars with no statistically significant differences between these two treatments.

Amicucci and coworkers<sup>62</sup> also compared the effects of a silicone gel cushion versus silicone occlusive sheeting in the treatment of hypertrophic and keloid scars. Over a few weeks to 5-month period, a cessation of itching and burning, followed by a flattening of the scar, was noticed in 78.2% of patients treated with the silicone gel cushion and 52.3% of patients treated with silicone occlusive sheeting (52.3%). Amicucci and coworkers<sup>62</sup> concluded that the silicone gel cushion treatment produces a faster response.

**Immunologic Effects** Investigators examining the effect of commercially available silicone gel sheeting (Cica-Care, Smith & Nephew, Memphis, TN) on six patients noted the disappearance of pain and pruritis after 12 weeks, which may be attributed to a decrease in the number of mast cells and the enhanced expression of Fas antigen by lesional fibroblasts after 24 weeks of treatment in one of the patients.<sup>15</sup> In a separate study with silicone gel sheeting, Santucci and colleagues<sup>65</sup> obtained biopsies from hypertrophic and keloid scars at baseline and at 12 weeks. After silicone treatment, they observed a reduction of spindle-shaped cells and an increased number of lymphocytes that strongly expressed CD11a/CD18 (LFA-1) adhesion molecules. Results from other *in vitro* studies suggest that silicone sheeting may act by down-regulating fibrogenic cytokine TGF- $\beta$ 2 or increasing bFGF and IL-8 levels.<sup>45,49,50</sup> Nonsilicone occlusion studies of clinically normal skin are of equal importance and have found increased levels of epidermal mononuclear cells and morphologic alterations in the Langerhans cells after occlusion.<sup>66–68</sup>

### **Clinical Efficacy of Silicone Elastomer Sheeting Products**

The efficacy of silicone elastomer sheeting for the treatment and prevention of hypertrophic and keloid scars has been evaluated in several small clinical trials. Owing to the difficulty of inclusion of an active treatment group in these studies, some of them used no treatment as the control arm.

### Treatment Trials

Perkins and colleagues<sup>69</sup> first described successful treatment of burn scars with silicone elastomer sheeting in 1983. Attempts by other researchers to document the efficacy of silicone treatment have followed.<sup>10,70-82</sup> Ahn and colleagues<sup>14</sup> applied silicone gel sheeting to 14 hypertrophic scars in 10 patients for a period of 8 weeks, leaving an area of each scar untreated to serve as a control. Eleven of the 14 scars were treated for at least 12 hours per day. Elasticity, as measured by a hand-held elastometer, was increased at 1 ( $p < .03$ ) and 2 ( $p < .01$ ) months in the treated scars compared with baseline and untreated scars ( $p < .05$  and  $p < .03$ , respectively). Scar texture, color, thickness, durability, presence of pruritus, and range of motion were evaluated subjectively. All of the patients that wore the silicone gel sheeting for at least 12 hours per day indicated a desire to continue treatment after the study period.<sup>14</sup> Similar results were obtained when silicone gel sheeting was applied to one-half of a hypertrophic scar or keloid in 21 patients for 12 weeks;<sup>83</sup> the other half of the scar received no treatment. Subjective evaluation of these scars by a physician indicated moderate improvement in 10 of 21 patients (47.6%) and minimal improvement in 9 of 21 patients (42.9%).

Two types of silicone gel sheeting (Silastic gel sheeting, Dow Corning, Midland, MI; and Cica-Care, Smith & Nephew) were compared to no treatment in 42 patients with 47 hypertrophic scars. The two types of silicone gel sheeting were similar. After 6 months, 93% of the scar areas treated with Cica-Care and 100% of the scar areas treated with Silastic gel sheeting were rated as improved, compared with only 38% in the control group.<sup>84</sup>

Additional studies have confirmed the efficacy of new silicone vehicles in the treatment of scars. Eisen<sup>85</sup> conducted an open-label pilot study with a topical liquid containing 12% silicone, 0.5% hydrocortisone, and vitamin E (Scarguard, Red Rock Laboratories, LLC, Great Neck, NY). After 8 weeks

of topical liquid scar treatment, 9 of 12 patients reported a reduction in erythema and overall appearance, 6 patients reported a decrease in induration, and 5 patients noted the scar was less raised. Even though Baumann and Spencer<sup>86</sup> reported no benefit in the cosmetic outcome of scars after topical application of vitamin E, vitamin E has been advocated as an anti-inflammatory agent capable of reducing the number of fibroblasts and retarding the accumulation of collagen.<sup>87</sup> A separate study found silicone gel sheets enhanced with vitamin E to be superior over silicone alone in the treatment of hypertrophic and keloid scars.<sup>88</sup>

de Oliveira and colleagues<sup>55</sup> have found that the silicone component of scar dressings may not be necessary for efficacy in scar management. In their study, they compared treatment of hypertrophic and keloid scars with silicone versus nonsilicone dressings versus no treatment in 26 patients with 41 scars. After 4.5 months, the treated groups had significantly shorter ( $p = .01$ ) and narrower ( $p = .001$ ) scars than the control group. Additionally, scar color was significantly paler ( $p < .001$ ) and induration was significantly decreased ( $p < .0001$ ) in the treatment groups compared with the control group. No significant differences were noted between the groups treated with silicone and nonsilicone dressings.

The efficacy of silicone gel sheeting in the treatment of hypertrophic and keloid scars has not been demonstrated in all studies of the device. Tan and colleagues<sup>89</sup> studied the differences between no treatment, application of silicone gel sheeting, and injection of triamcinolone acetonide in 20 patients with keloids. Results showed that triamcinolone acetonide injection was superior to both silicone gel sheeting ( $p < .05$ ) and no treatment ( $p < .05$ ) with respect to scar size, color, texture, and symptoms of pain and pruritus. There was no significant difference between the same parameters in scars treated with silicone gel sheeting and those that were not treated. Similarly, results from a separate study show that when hypertrophic scars were divided

into three sections and each section was assigned silicone gel sheeting, flashlamp-pumped pulsed-dye laser, or no treatment, there was no significant difference noted among the three sections with regard to blood flow, elasticity, scar volume, or histologic assessment.<sup>90</sup>

### **Prevention Trials**

The prevention of hypertrophic and keloid scar formation by silicone elastomer sheeting has also been studied.<sup>10,72,83,91-94</sup> In a controlled trial of 20 women who were undergoing bilateral reduction mammoplasties, silicone elastomer sheeting was applied to the scars on one breast on Postoperative Day 14, whereas the scars on the other breast remained untreated.<sup>92</sup> The silicone sheets were held in place with adhesive skin closures (Steri-Strips, 3 M, St. Paul, MN) and a brassiere and were worn for 12 hours per day for 2 months. After 2 months, 60% of the untreated scars and 25% of the treated scars had become hypertrophic ( $p < .05$ ). The treatment effect remained after evaluation at 6 months, at which time 55 and 25% of untreated and treated scars, respectively, exhibited hypertrophy ( $p < .05$ ). Similar results were obtained from a separate study, in which 29 patients with surgical incision scars from procedures occurring 8 months or less before the study wore silicone elastomer sheeting on portions of their scars.<sup>91</sup> Each patient served as his or her own control by leaving a portion of the scar untreated. The silicone sheeting was worn for 12 to 24 hours per day for 2 months and improvement when compared to baseline was measured at 1 and 2 months by objective assessment of scar volume. Upon evaluation at 1 and 2 months, scar volume of control scars was greater than that of test scars ( $p = .08$  and  $p = .003$ , respectively). A treatment-time effect on test scar volume was identified ( $p = .03$ ).

A positive treatment effect is not always reported when hypertrophic and keloid scars are treated with silicone elastomer sheeting.<sup>93,94</sup> A total of 155 patients undergoing bilateral breast reduction received

treatment with silicone elastomer sheeting or silicone gel on half of their scars and no treatment on the other half of their scars.<sup>94</sup> The investigators reported that 64.3% of patients developed hypertrophic scars after 3 months and concluded that neither silicone elastomer sheeting nor silicone gel had an effect on prevention of hypertrophic scarring. In another study, 66 patients undergoing minor dermatologic surgery were stratified as either high or low risk for abnormal scarring based on history of development of hypertrophic or keloid scars<sup>93</sup> and were randomized to treatment with silicone elastomer sheeting or routine wound care. The treatment group applied silicone sheeting to their wounds 48 hours after surgery and wore the sheets for 12 to 24 hours per day for 6 months. No significant difference was detected between the treatment and control groups; however, a subset of patients in the high-risk group whose surgery was identified as "scar revision" derived benefit from treatment with silicone elastomer sheeting, and only 4 (36%) of the treated patients had scar recurrence. Scars recurred in 10 scar revision patients (83%) in the control group ( $p = .035$ ).

The published studies conducted to assess the efficacy of silicone gel sheeting for improvement of hypertrophic and keloid scars have shortcomings. All of the studies suffer from a small sample size, lack of objectivity in measurement of parameters that assess efficacy, lack of standardization of the patient population, and lack of control over patient compliance. Because of the similarities in the characteristics of hypertrophic and keloid scars, the two types of scars are often not evaluated separately, and the age and origin of the scars, although usually reported, are not analyzed consistently. Perhaps enrollment of larger numbers of patients with more uniform scar characteristics would provide further evidence regarding the efficacy of silicone elastomer sheeting for treatment and prevention of hypertrophic and keloid scars. Furthermore, patient compliance with silicone gel sheeting may be increased with enhanced patient education in the form of handouts and detailed multimedia.<sup>95</sup>

## Safety Experience

Silicone elastomer sheeting is generally well tolerated by patients with hypertrophic and keloid scars.<sup>96–102</sup> A discussion of the safety of silicone elastomer sheeting encompasses both a description of the adverse events encountered in clinical trials and a report of studies designed to detect the presence of silicon in skin that has been in contact with silicone. Adverse events that have been reported in clinical efficacy trials are mild and include pruritus,<sup>98,100,102</sup> contact dermatitis,<sup>96–102</sup> skin breakdown,<sup>100,102</sup> skin maceration,<sup>98,100</sup> dry skin,<sup>98</sup> and odor emanating from the gel sheet.<sup>100</sup> Adverse effects occurred infrequently and were commonly associated with poor hygiene.<sup>96–102</sup> Pruritus and skin rash, skin breakdown, and skin maceration usually resolved within 12 to 48 hours after the removal of the gel sheet.<sup>96–100</sup> In some cases, treatment was resumed without incident after a change in the brand of the silicone gel sheet.<sup>100</sup> It is important to note that not all episodes of skin rash occurred in the skin under the gel. In some instances, skin irritation and rash were observed under the adhesive tape holding the gel in place.<sup>96,98,100,101</sup> Alcohol may be used to remove this adhesive tape to avoid inadvertent removal of layers of skin.<sup>101</sup> Dry skin was treated with application of moisturizer to the scar and episodes of malodorous gel sheets were resolved with institution of better hygiene by washing the scar and gel sheet more frequently with mild soap and water.<sup>98,100</sup> These adverse effects can be avoided by building up wearing time, beginning with approximately 2 hours per day and gradually increasing to 12 to 24 hours per day as tolerated.<sup>7,103–105</sup>

The paucity of adverse events reported in clinical trials of silicone gel sheeting suggests that the presence of silicon in the skin does not contribute to the incidence of adverse events. Silicone elastomer sheeting products are safe and have minimal potential to cause harm, as substantiated by the absence of case reports in the literature describing serious adverse effects. If adverse effects do occur, they can be managed by temporary interruption of therapy, reduction of wearing time, and instruction in better hygiene.<sup>7,103–105</sup>

## Clinical Use for Scar Management

Silicone elastomer sheeting can be used for the treatment of hypertrophic and keloid scars resulting from many types of wounds, including burns, other accidental injuries, or surgical incisions.<sup>9,105,106</sup> Because the reasons for development of hypertrophic and keloid scars are not clear, the mechanisms of action of many of the available treatments are unknown, and treatment responses vary among different scars. Many clinicians adopt a multimodal approach to the treatment and prevention of hypertrophic and keloid scars. Treatment options other than silicone elastomer sheeting include intralesional injection of corticosteroids, radiation, laser treatment, surgical excision, cryotherapy, and pressure therapy.<sup>7,9,107–109</sup> Silicone elastomer sheeting is generally used in conjunction with other minimally invasive treatments as a first-line treatment for small, minor hypertrophic, and keloid scars.<sup>9</sup> Recalcitrant scars, or those that are very large or particularly serious, are usually treated with more invasive measures, but silicone elastomer sheeting may still be used as an adjunct to increase the likelihood of scar improvement.<sup>9,109</sup>

The ease of use of silicone elastomer sheeting and its lack of serious adverse effects make it an attractive alternative to more invasive treatments, such as intralesional injection of corticosteroids, radiation, laser treatment, surgical excision, cryotherapy, and pressure therapy.<sup>9</sup> Surgical revision of scars carries the risks common to all surgical procedures, and the recurrence rate of hypertrophic and keloid scars after surgical revision is high (45%–100%).<sup>110–113</sup> Injection of corticosteroids into the scar can cause significant pain, skin atrophy, depigmentation, and telangiectasias.<sup>114</sup> Pressure therapy is expensive because pressure garments are custom-made and must be replaced as they wear out and a patient grows or loses or gains weight.<sup>103,104</sup> Pressure garments can also be uncomfortable and patient compliance is poor.<sup>102,108,115</sup> Radiotherapy is controversial because of the possibility of carcinogenesis.<sup>109</sup> High scar recurrence rates have been noted with laser therapy,<sup>9</sup> and cryotherapy commonly causes permanent hypopigmentation.<sup>116</sup>

It is generally accepted that prevention of hypertrophic and keloid scar formation is easier than treatment of an established scar.<sup>9,104</sup> Silicone elastomer sheeting has been used in the prevention as well as treatment and is particularly well suited to both uses because it exposes the patient to very little risk of adverse events, in contrast to treatments such as surgical excision, radiation, intralesional corticosteroid injections, and laser therapy.<sup>9</sup>

Some silicone elastomer sheeting products are available over the counter and are often purchased by patients upon recommendation of a health-care professional. Methods of application of silicone elastomer sheeting to scarred skin include fixation with gentle adhesive tape and/or covering with a tubular bandage.<sup>104,117,118</sup> Some products, such as antibiotic ointment (Neosporin, Johnson & Johnson, New Brunswick, NJ), silicone scar sheets (Scar Solution, Johnson & Johnson), and scar healing strips (BAND-AID brand scar healing strips, Johnson & Johnson), are self-adhesive and thus offer the advantage of not requiring adhesive tape.<sup>28,119</sup> Other means of application combine silicone therapy with pressure therapy, such as silicone orthoses, pressure garments with a silicone interface, and inflatable silicone inserts that can be used in concave areas or on soft tissue.<sup>39,105</sup>

Researchers who have studied the application of silicone elastomer sheeting in clinical practice have found that the sheet must be worn for at least 12 hours per day for 2 to 3 months to be effective.<sup>7,9,104,107,109,118</sup> Patients may notice slight improvements in the appearance and feel of their scars within 1 week, and more noticeable improvements may be evident after the full treatment period.<sup>106</sup> The sheet and the scar should be gently but thoroughly washed with mild soap and warm water at least once daily, and the sheet should be replaced when it begins to disintegrate. It is important to note that silicone elastomer sheeting should not be used on open wounds or unhealed skin.<sup>7,9,104,107</sup>

## Conclusions

During the past 30 years, silicone sheeting products have been refined to maximize adhesiveness and durability, making them easier to use. Other treatment options for hypertrophic and keloid scars, such as intralesional injection of corticosteroids, radiation, laser treatment, surgical excision, cryotherapy, and pressure therapy, may be associated with problematic adverse effects and require involvement of a physician or physical therapist. Silicone elastomer sheeting, however, is available over the counter and requires only minimal monitoring by a physician for safe and effective use.

Although the mechanism of action of silicone elastomer sheeting has not been completely elucidated, it appears to be an effective means of treating and preventing hypertrophic and keloid scars and can be used with little risk of serious adverse effects. Data regarding efficacy of silicone elastomer sheeting products for the treatment and prevention of hypertrophic and keloid scars may provide further evidence by execution of larger, controlled clinical trials. Silicone elastomer sheeting can also be used as part of a multifaceted approach to scar management and can be used in combination with other effective therapies. Clinicians have recommended that silicone elastomer sheeting be in contact with the scar for 12 to 24 hours per day for 2 to 3 months, with removal permitted for routine hygiene. Adverse events such as pruritus, rash, maceration, and odor can be managed by temporary interruption of treatment and regular washing of the sheet and the scar.

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Address correspondence and reprint requests to: Oliver A. Perez, MD, Department of Dermatology and Cutaneous Surgery, University of Miami, Miller School of Medicine, 1600 NW 10th Avenue, RSMB, Room 2023 A (R250), Miami, FL 33136, or e-mail: [dermatology.research@med.miami.edu](mailto:dermatology.research@med.miami.edu)

## COMMENTARY

This article by Berman and colleagues is an important review for practitioners who face the challenge of treating hypertrophic scars and keloids in their clinical practices. The article very nicely describes the differences between these difficult to treat lesions and reviews their etiologies as well as offers the various treatment options used to treat hypertrophic scars and keloids. It describes the properties of silicone elastomer sheetings and goes over the various proposed mechanisms of actions for silicone elastomer sheetings. These include increased temperature, hydration as a result of occlusion of the underlying skin, increased oxygen tension within the scars, direct release of silicone into the skin, and polarization of the scar by negative static charge. Most of the early literature seemed to focus on the hydration/occlusion principle for the mechanism of action of silicone elastomer sheetings, although no one has yet to fully elucidate how these products work to flatten hypertrophic scars and keloids.

The authors review the major clinical trials that support the use of silicone elastomer sheetings in the treatment of these lesions and further strengthen the case that these products should be utilized when clinicians are confronted with these lesions. As noted in the article by Mustoe and colleagues,<sup>1</sup> silicone gel sheets have a major role in the initial therapeutic approach to hypertrophic scars and keloids, with more controlled clinical trials having been performed than with most other treatment modalities. The authors then end with a review of the potential adverse events with these materials, but the majority of clinical trials have confirmed their safety profile.

I have utilized silicone gel sheets in my clinical practice for a number of years. The research we have performed and published suggests that they have an effect on flattening these raised lesions and returning the color back toward normal and may have a preventative effect in those individuals with a history of abnormal scarring.<sup>2–4</sup> The literature suggests that this treatment is best used on what are typically defined as fresh scars, those less than 2 years old. Reports of hypertrophic scars and keloids present for longer durations, however, have also responded to this treatment modality.

In my practice, anyone who has a hypertrophic scar or a keloid is initially treated with a silicone gel sheet. On occasion, this is the only therapy we will utilize. The patient is instructed to wear the sheet for upwards of 12 to 24 hours per day and are told it may take upwards of 2 to 3 months before an effect may be seen. As described in the article by Mustoe and coworkers,<sup>1</sup> other treatment options, such as intralesional corticosteroids, are also useful early and are the standard of care for these lesions. So, in my practice it is customary for my patients to receive combination therapy, with both intralesional cortico-

steroids, given in the office, and topical silicone gel sheeting, to be used at home. This gives the patient some ownership in his or her therapy, something that I feel important in treating many patients. Also on occasion, laser therapy, mainly with the pulsed dye laser or the intense pulsed light source, is also added to the therapeutic combination, to help reduce the vasculature to the lesions.

Hypertrophic scars and keloids are, at present, difficult-to-treat skin lesions. Silicone elastomer sheetings, of many varieties, have shown the test of time since their original descriptions in the burn literature in 1982<sup>5</sup> and my first report in the dermatologic literature in 1993.<sup>2</sup> Although their exact mechanism of actions has not been fully elucidated, they work clinically and are safe and quite frankly should be part of all hypertrophic scar and keloid therapy for your patients.

MICHAEL H. GOLD, MD  
*Nashville, TN*

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# The Efficacy of Topical Silicone Gel Elastomers in the Treatment of Hypertrophic Scars, Keloid Scars and Post Laser Exfoliation Erythema.

W. Gregory Chernoff, B.Sc., M.D., F.R.C.S.C., Chernoff Plastic Surgery and Laser Center, Santa Rosa, CA, USA  
Melissa L. Earl, MPH, IMEDS, Riverside, CA, USA

## INTRODUCTION:

Hypertrophic scars affect an estimated 20% of the population.<sup>1</sup> In dark-skinned populations such as Asian, African and Mediterranean people, the incidence rises to over 40%.<sup>2</sup> Keloids represent approximately 4% of hypertrophic scars.<sup>3</sup> While a variety of therapeutic modalities have been attempted, the majority of medical and surgical specialties treating these problematic scars agree that these are notoriously difficult to treat.<sup>4</sup>

For decades, scars were accepted phenomena, and patients were told that there was little that could be done and that they had to accept the appearance of their scars. Yet most patients do not accept that "nothing can be done," and they would accept even a slight improvement in the overall appearance of a scar as compared to a disfiguring result, which can have a very adverse effect on self-esteem. The negative consequences of disfiguring scars have motivated researchers to attempt to modify the healing process to improve the appearance of scars and reduce the physical and emotional disabilities that result from abnormal scarring.

A variety of treatments for hypertrophic scars and keloids have been advocated in the past. These include intralesional steroids, cryosurgery, radiotherapy, pressure therapy, silicone gel sheeting, laser therapy, excisional surgery and topical silicone gels.<sup>5</sup> Recurrences remain common, and patient satisfaction is variable.<sup>5</sup>

Topical silicone gel has recently been shown to be effective in the prevention of hypertrophic scarring, with beneficial results similar to those provided by silicone gel sheeting and pressure dressings.<sup>6</sup> An advantage of a silicone gel is its ease of application and effortless maintenance.

Dermatix® Gel, a silicone polysiloxane derivative, is a FDA registered substantial equivalent to silicone elastomer gel sheeting for the management of hypertrophic scars and erythema associated with exfoliation laser therapy.

## PURPOSE:

- The purpose of this study was to determine the efficacy of topical silicone gel (Dermatix®, Valeant Pharmaceuticals International) in the treatment and prevention of hypertrophic scars, keloid scars, and erythematous scars resulting from laser exfoliation.

## METHODS:

- One hundred (100) consecutive patients who presented with scars were screened for entry into this study.
  - This patient population included 64 females and 36 males. A total of 140 scars were evaluated at screening.
  - Of these 140 scars, 71 were located on the face, 25 on the abdomen, 10 on the breast, 8 on the neck, 5 on the sternum, and 1 on the buttock.
- Scars that were still in the erythematous and raised stage of healing, hypertrophic scars, and keloid scars were deemed appropriate for study.
- Scars that were determined to be dormant and mature by virtue of their flatness, lack of erythema, or lack of pigmentation were excluded from this study.
- Patients (n=30) who had bilateral, active scars were included in the study.
  - One scar was treated and the other was used as an untreated control.
- Each patient was assigned to 1 of 3 treatment groups.
  - Patients in the first group applied the polysiloxane derivative Dermatix® (Valeant Pharmaceuticals International) to the treated scar twice daily (morning and evening).
  - Patients in the second group applied silicone gel sheeting.
  - Patients in the third group applied Dermatix® in the morning and used silicone gel sheeting at night.

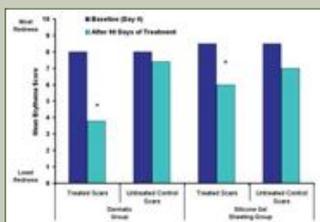
## Outcome Measures:

- The treated and control scars were examined at visits after 30, 60, and 90 days.
- Evaluations included erythema, surface topological elevation, and overall softening of the scar.
- Skin surface texture and architecture was measured objectively using a computer assisted digital imaging program (optical profilometry) and scar elevation was analyzed.
- Subjective evaluations of the healing scars were made by the patients and the physician at each visit using linear analogue scores.
- Histological punch biopsies were obtained before and after treatment for specific examination of the orientation and pattern of the collagen fibers.

## Itching, Irritation, and Skin Maceration

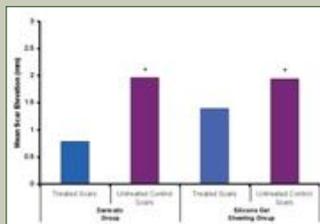
- Overall, 60% of the control scars involved in the study were symptomatic, but patients described minimal symptoms related to pain, burning, or itching in scars treated with either Dermatix® gel, silicone gel sheeting, or both modalities.
- Treatment with either Dermatix® or silicone gel sheeting reduced symptoms of itching, irritation, or skin maceration in comparison with untreated scars
  - Patients reported less itching and scars exhibited less maceration with Dermatix® treatment than with the silicone gel sheeting.

Figure 1. Erythema scores in scars treated with Dermatix® or gel sheeting and in untreated control scars.



- Scars treated with Dermatix® showed earlier and greater dissipation of erythema compared with scars treated with silicone gel sheeting.
  - Erythema was rated on a linear analogue scale from 0 = none to 10 = red. \*P < .001 vs untreated control scar in same patient at day 90 (paired t-test)
- The decrease in mean erythema scores from baseline to day 90 was 4.26 units with Dermatix® treatment and 2.52 units with silicone gel sheeting treatment.
  - By comparison, the decrease was 0.77 units and 1.21 units in the untreated control scars in the Dermatix® and silicone gel sheeting groups, respectively.

Figure 2. Mean scar elevation after 90 days of treatment.

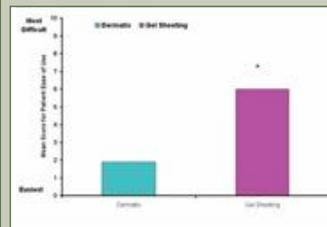


- Treated scars showed improvement in comparison to the untreated control scars on all parameters in each of the treatment groups (P<.001).
  - However, scars treated with Dermatix® showed superior leveling compared with scars treated with silicone gel sheeting.
- The difference between treatments was maximized at 90 days.
  - At day 90, the mean elevation of scars treated with Dermatix® was 0.79 mm, compared with 1.39 mm for scars treated with gel sheeting.
  - Untreated control scars in the Dermatix® and gel sheeting treatment groups showed a similar higher elevation at day 90 (1.96 and 1.94 mm, respectively).
  - The decrease in mean scar height from baseline was 1.5 mm with Dermatix®, 1.0 mm with silicone gel sheeting, and 0.35 mm in the untreated control scars.
- Facial scars appeared to have the best results with Dermatix® gel compared to the silicone gel sheeting (Figure 3).

Figure 3. Facial scars and post-laser erythema improved after 90 days of Dermatix® gel treatment.

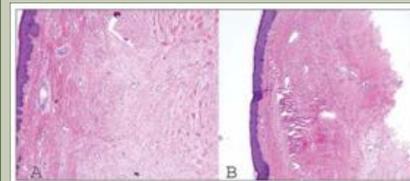


Figure 4. Patient evaluation of ease of use of Dermatix® Gel and Silicone Gel Sheetting



- Patients subjectively ranked Dermatix® far superior to gel sheeting in ease of use as well as in their willingness to comply with the treatment regimen (\*P<.001).
- Scale was 0 = easiest to use and 10 = most difficult.

Figure 5. Histological evaluation of an excised keloid that was treated with Dermatix® (A) and an untreated control keloid (B).



- On histological examination, the collagen bundles appeared looser and were more parallel to the surface of the skin in treated scars compared with the thick, twisted bundles of collagen in the untreated control scars.
- Mast cells are known to be important in the remodeling phase of wound healing,<sup>7</sup> and the number of mast cells was increased in scars treated with either Dermatix® or silicone gel sheeting.
- There were a normal number of mast cells in untreated control scars.

## DISCUSSION

- Evaluation of patients with more than one scar in this study provided a unique ability to utilize the patient's own skin as a control for comparison of the effects of Dermatix®, silicone gel sheeting, or a combination of these treatments on active scars and for the prevention of permanent scars.
- Dermatix® treatment was at least as effective as silicone gel sheets for reducing erythema, elevation, and itching and was associated with no maceration.
  - Moreover, Dermatix® was preferred by patients for ease of use
- It has long been known that pressure therapy for healing scars or hypertrophic scars can accelerate the remodeling phase of healing.<sup>1</sup>
  - A drawback to topical silicone sheeting has been the difficulty that many patients have in keeping the sheeting in place throughout the night without taping.
  - Patients frequently object to wearing silicone sheeting during the day because of its unsightliness and potential for discomfort.
- The advent of topical silicone gel adds an important element to the armamentarium of the physician treating scars and healing wounds.
  - The greatest advantage that Dermatix® offers is its ease of application and effortless maintenance yielding improved patient compliance.
  - Dermatix® is easier to use as a treatment modality on areas such as the face and areas of movement associated with joints.
  - The end result of this therapy is improvement in scar height and decreased erythema with improved skin texture and elasticity.
- Histological examination of the scar tissue treated with Dermatix® in this study consistently showed decreases in sclerotic collagen compared to untreated scars.

## CONCLUSIONS

- Silicone topical elastomer gel (Dermatix®) offers an effective addition to the armamentarium of the physician in treating healing surgical wounds, traumatic wounds, and hypertrophic scars and keloids.
- The advantage of Dermatix® over Silicone Gel Sheetting was its ease of application and around the clock coverage.
- Dermatix® was also absent of skin breakdown, maceration, and itching associated with gel sheeting.
- Dermatix® provides a thin membrane which caused no skin breakdown whatsoever.
- Dermatix® was also much easier to use as a treatment modality on areas such as the face and areas of movement associated with joints.

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## Evaluation of a self-adherent soft silicone dressing for the treatment of hypertrophic postoperative scars

**• Objectives** The primary objective was to compare the efficacy of a self-adherent soft silicone dressing (Mepiform) with 'left alone' management of hypertrophic scars using the Vancouver Scar Scale. Secondary objectives were to follow photographs of the scars, patients' opinions of the scars, and doctors' and patients' assessments of the overall dressing performance, safety and tolerance.

**• Methods** An exploratory open randomised controlled clinical investigation was undertaken on 11 female patients aged 21–43 years with postoperative scars (nine following breast surgery, two following lower abdominal-gynaecology). Treatment was initiated between two weeks and two months (mean 4.7 weeks) after surgery. Ten patients completed the 12-month investigation; one patient in the treatment group discontinued for personal reasons.

**• Results** All parameters in the Vancouver Scar Scale improved in both groups, although patients treated with the soft silicone dressing showed greater and more rapid improvement compared with the non-treated patients, while their assessments of the condition of the scar were more favourable. Medical staff rated the overall dressing performance as 'very good' or 'good'. One adverse event was reported – local skin irritation at the site of the scar.

**• Conclusion** The results suggest that patients treated with the soft silicone dressing experienced greater and more rapid improvements compared with non-treated patients. These results concur with those of previous studies. The fact that Mepiform is self-adhesive and causes limited damage to the stratum corneum on removal gives it an added value compared with non-adhesive silicone gel dressings.

**• Declaration of interest** This study was supported by Mälarycks Health Care AB, Gothenburg, Sweden.

postoperative scarring; hypertrophic scar; self-adhesive soft silicone dressing

A variety of techniques are used in the management of hypertrophic scars. However, the evidence base for many treatments is poor, and some may have only a placebo benefit.<sup>1</sup> This may be in part due to the difficulty in assessing the efficacy of treatment methods as scars have a natural tendency to improve over time.<sup>2</sup>

A study design with randomisation, an adequate control group and long-term follow-up is therefore required to facilitate conclusions about efficacy. The aim of this open randomised controlled one-year clinical investigation was to compare the efficacy of a self-adherent soft silicone dressing (Mepiform, Mälarycks Health Care AB, Gothenburg, Sweden) with no treatment in patients with hypertrophic scars following plastic surgery.

### Method

#### Participants

The participants were recruited from patients having elective surgery for burns or plastic surgery at the Special Sciences Institute, Department of Plastic Surgery, Malmö, Spain. Eligible patients were adults aged 18 years or older with postoperative scarring

who were attending the outpatient clinic. According to Mouton,<sup>3</sup> such procedures have a high incidence of hypertrophy resulting.

Patients were excluded from the study if they:

- Suffered from an underlying disease (judged by the investigator to possibly interfere with the treatment of the hypertrophic scar (for example, cancer)
- Had a known hypersensitivity to the product used in the study
- Were unable to comply with the study procedures and/or attend the clinic for follow-up visits
- Had any type of keloid scar as treatment for other keloid scars requires a combination of silicone dressings and intralesional corticosteroids, while major keloids can be treated with amthasterone and, in some cases, radiation.<sup>4</sup>

#### Study design

The study was performed in accordance with the ethical principles set forth in the Declaration of Helsinki. Written informed consent was obtained from all patients participating in the study. Since this was an explorative pilot study it was determined that 12 would be a suitable number of patients.

Participants were randomly allocated to one of

Dr. Carlos Melán, MD  
Department of Plastic  
Surgery, Special Sciences  
Institute, Faculty of Health  
Sciences, Malmö, Sweden  
Email: carlos.melan@malmsk.se

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Table 1. Patient demographics

Patient	Treatment	Wound aetiology	Underlying disease	Other major injury	Type of scar	Time since surgery	Previous treatment of scar
1	Hydrocolloid	Normal	None	Spinal (lower) fracture	Flaring, raised	2 weeks	None
2	Control	Normal	None	None	Flaring, raised	2 months	Pressure garment
3	Hydrocolloid	Normal	None	Head	Flaring, raised	2 weeks	Local cream
4	Control	Normal	None	None	Flaring, raised	3 weeks	Topical cream
5	Control	Normal	C6 fracture	Neurovascular	Flaring, raised	3 weeks	None
6	Hydrocolloid	Normal	None	None	Flaring, raised	2 weeks	None
7	Hydrocolloid	Normal	None	None	Flaring, raised	1 month	Topical cream
8	Control	Normal	None	Wrist (ulnar)	Flaring, raised	1 month	None
9	Control	Major injury (ulnar fracture, ligamentous injury)	None	Geometric	Flaring, raised	1 month	Pressure garment
10	Hydrocolloid	Normal (ulnar fracture, ligamentous injury)	None	Geometric	Flaring, raised	1 month	Pressure garment
11	Hydrocolloid	Normal	None	Spinal (lower) fracture	Flaring, raised	2 months	None

\*Patient 7 developed a surgical scar which was the subject of the study.

\*\*Patient 10 was the only patient.

†Patient 9 developed a surgical scar which was the subject of the study.

the two treatment options by a predetermined computer-generated randomisation list.

Blinding was not possible as this was a dressing versus no dressing study, therefore an open design was used. In addition, at our clinic patients with hypertrophic scars do not normally receive any treatment during the first year after surgery as options such as silicone gel sheeting have only recently become available.

#### Interventions

Participants were randomised either to treatment with the self-adherent soft silicone dressing or no treatment. They were advised to use the dressing for about 23 hours per day and to reapply the same sheet until adherence was judged to be insufficient, or for a maximum of one week.

#### Endpoints

Participants were evaluated at baseline, monthly up to six months and after 12 months.

The primary objective was to evaluate improve-

ments in scar characteristics according to the Vancouver Scar Scale,<sup>7</sup> which includes the following parameters:

- Pigmentation
- Height
- Flexibility
- Vascularity

Other endpoints were:

- Photographs of the scar taken at baseline and after 12 months
- Participants' views on the condition of the scar (smooth, dry, moist, hard, itchy and pain) at baseline and at each follow-up visit
- Participants' and investigators' assessment of overall dressing performance after 12 months
- Adverse events noted at each follow-up visit.

#### Statistical methods

In this exploratory investigation the sample size was not calculated based on a predicted power to detect a significant difference for the primary endpoint. The aim was rather to obtain information to serve as

a basis for designing future confirmative investigations. The results are presented in a descriptive manner without calculation of p values.

## Results

### Participants

Eleven female patients (six in the treatment and five in the control group) were randomised and enrolled into the study. In the dressing group the mean age was 28.6 years (range 20–43) and in the control group it was 29.4 years (range 22–60). Other demographic data are given in Table 1. None had had breast surgery and two lower abdominal gynaecology due to cancer. Treatments were lettered between two weeks and two months after surgery. Ten participants completed the 12-month investigation; one in the treatment group discontinued the study due to personal reasons.

### Efficacy

During the study period all scars, including those in the control group, improved according to the Vancouver Scar Scale. However, as seen in Fig 1, the improvement was greater in the treatment group. Individual patient results at baseline and 12-month follow-up are given in Table 2. Most improvement in pigmentation, height, pliability and vascularity took place in the period up to the six-month follow-up visit. The further improvements up to the 12-month follow-up visit was similar in the two groups.

Fig 2 shows scars in one participant before (a) and after (b) 12 months of treatment.

At baseline three participants in each group judged their scars to be 'hard'. After six months all those in the dressing group judged their scars to be 'sandy', while two in the control group still considered their scars to be 'hard'.

The doctor's assessment of overall dressing performance was 'very good' or 'good' in all participants, while participants' own assessments were 'very good' or 'good' in four out of five cases.

### Safety

One adverse event was reported during the study. The participant experienced a local skin reaction at the site of the scar and discontinued dressing use. After one month her skin had returned to its normal condition and she resumed the treatment; the skin reaction did not reappear.

### Discussion

Each year in the developed world 100 million people acquire scars, some of which cause considerable problems.<sup>7</sup> Global figures are unknown but doubtless much higher. People with abnormal skin scarring may face physical, esthetic, psychological and social consequences that may be associated with substantial emotional and financial costs. Those who undergo plastic surgery for aesthetic reasons

Fig 1. Vancouver Scar Scale results: pigmentation, height, pliability and vascularity

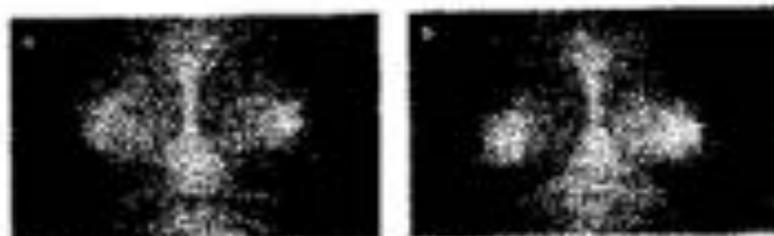
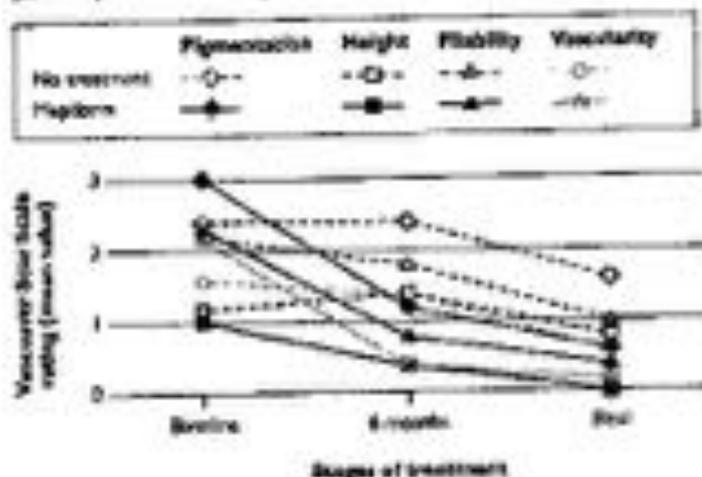


Fig 2. One participant's scar before (a) and after (b) 12 months' treatment

may be particularly sensitive to disfiguring scars.

Scar repair results in a broad spectrum of scar types, ranging from a fine line to a variety of abnormal scars such as widespread scars, atrophic scars, scar contractures, hypertrophic scars and keloid scars. Raised scars are described as hypertrophic or keloid. Linear hypertrophic scars are red, raised, sometimes itchy and confined to the border of the original surgical incision. Scars may increase in size rapidly for three to six months and then, after a static phase, begin to regress. They generally mature to have an elevated, slightly rope-like appearance, with an increased width. The full maturation process may take up to two years.

Objective scar assessment is essential for diagnosis and for starting, monitoring and evaluating a therapeutic strategy for scar management. The severity of scars is often judged by eye but can be assessed quantitatively with a scar assessment guide such as the Vancouver Scar Scale.<sup>8</sup> A standardized colour photograph of the scar lesion provides a reference with which to evaluate the effectiveness of treatment. Due to the natural tendency for scars to improve over time it is important in clinical trials to have a control group, allocate participants to treatment or control group by proper randomisation,



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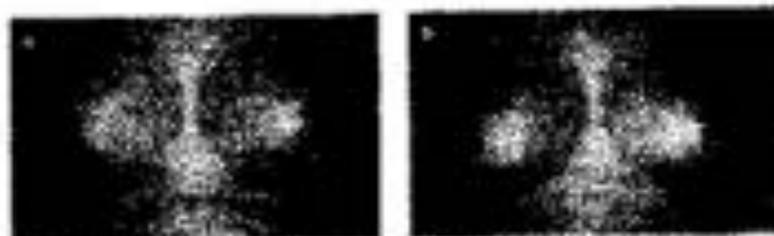
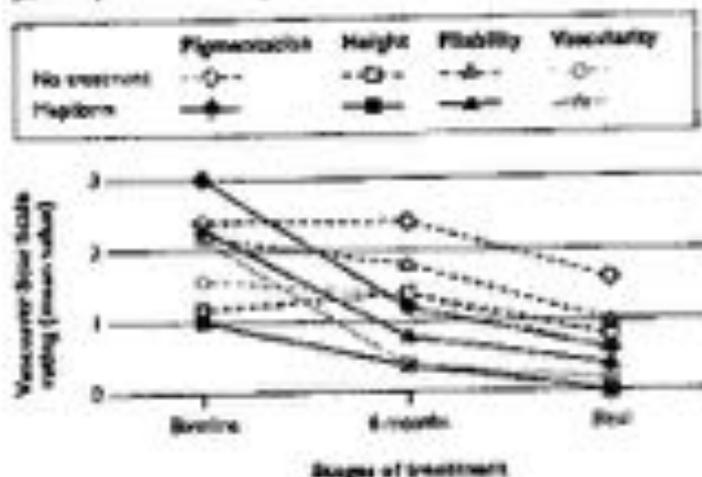


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B. H. M. van't Hof-Grootenboer, M.D.,  
Ph.D.,  
Department of Plastic and Reconstructive  
Surgery, University Hospital Groningen,  
Groningen, The Netherlands

F. C. van't Hof-Grootenboer, M.D.,  
Ph.D.,  
Department of Plastic and Reconstructive  
Surgery, University Hospital Groningen,  
Groningen, The Netherlands

B. H. M. van't Hof-Grootenboer, M.D.,  
Ph.D.,  
Department of Plastic and Reconstructive  
Surgery, University Hospital Groningen,  
Groningen, The Netherlands

B. H. M. van't Hof-Grootenboer, M.D.,  
Ph.D.,  
Department of Plastic and Reconstructive  
Surgery, University Hospital Groningen,  
Groningen, The Netherlands

Table 2. Vancouver Scar Scale data: individual patient data recorded at baseline and last visit (12 months)

Patient no.	Treatment	Visit no.	Hypertrophy	Height (mm)	Pliability	Visibility	Pressure therapy
1	Mepiform	1	3	1	3	3	No
		2	0	0	1	1	No
2	Control	1	3	3	3	3	No
		2	2	1	3	3	No
3	Mepiform	1	1	1	1	1	No
		2	1	0	1	0	No
4	Control	1	0	1	1	0	No
		2	2	1	1	1	No
5	Control	1	3	1	2	2	No
		2	2	1	1	1	No
6	Mepiform	1	3	1	2	2	No
		2	2	0	0	0	No
7	Mepiform	1	3	1	2	3	No
		2	2	1	3	2	No
8	Control	1	3	3	3	3	No
		2	1	0	1	0	No
10	Control	1	3	1	2	2	No
		2	1	1	1	0	No
11	Mepiform	1	0	1	2	2	No
		2	0	0	0	0	No
12	Mepiform	1	3	1	2	3	No
		2	2	0	0	1	No

Hypertrophy 0 = normal, 1 = hyperplastic, 2 = atrophic, 3 = hyperplastic  
Height 0 = flattened, 1 = flat, 2 = 3-5 mm, 3 = 5 mm  
Pliability 0 = normal, 1 = soft, 2 = firm, 3 = hard  
Visibility 0 = normal, 1 = good, 2 = not, 3 = worse  
Visit 1 = baseline, visit 2 = 12 months (data for all other visits, visit 3-12, to be obtained from the author)

and to follow up participants for a year or more.

An international advisory panel has recently issued international clinical recommendations on scar management.<sup>1</sup> The group reported a qualitative overview of more than 300 published references using standard methods of appraisal.

For prevention, the panel recommends silicone gel sheeting as the first-line option. Its use should begin soon after surgical closure, when the incision has fully epithelialized, and be continued for at least one month. Silicone gel sheets should be worn for a minimum of 12 hours daily, and if possible for 24 hours per day, with twice-daily washing.

For management of raised hypertrophic scars the panel recommends that silicone gel sheeting should be used as first-line therapy, in line with results from randomized controlled trials. If the scar is resistant to silicone therapy, or is severe and pruritic, further management with corticosteroid injections is indicated.<sup>2</sup> If silicone gel sheeting, pressure garments and intracutaneous corticosteroid injections are not successful after 12 months of conservative therapy, surgical closure with postoperative application of silicone gel sheeting should be considered.<sup>3</sup>

## Conclusion

The strengths of this exploratory investigation are the randomisation procedure, the control group and the one year follow up period.

There are two major limitations: the small sample size gives a low power to detect significant differences between the treatment and the control groups, and the open design increases the risk of bias in the assessments of scar characteristics.

However, the results of this study are in line with those of clinical trials with other silicone gel sheetings and in accordance with the results of other clinical studies on Mepiform.<sup>4,5</sup>

The fact that the study dressing is self-adherent gives it an added value as it may also be used in patients in whom the adhesive tapes used to secure non-adhesive silicone gel sheets cause discomfort and skin irritation.<sup>6</sup>

Mepiform has been shown to cause less damage to the stratum corneum of the skin upon repeated removal than other adhesive dressings.<sup>7</sup>

In conclusion, we consider that the self-adherent dressing should be explored as a first-line prophylaxis, and applied as soon as possible after surgical closure. ■

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Contact for further information:

Nova Pharmaceuticals Australasia  
Suite 305, 10 Norbrik Drive  
Bella Vista, NSW 2153  
Australia  
Phone: +61 2 8090 7855



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