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A cross-sectional report on melasma among Hispanic patients: Evaluating the role of oral tranexamic acid versus oral tranexamic acid plus hydroquinone

To the Editor: Oral tranexamic acid (TA) has been described as a game changer as a solo agent in the treatment for refractory moderate to severe melasma.[1] Its therapeutic mechanism has been postulated to address the vascular component in melasma. However, optimal dose, duration, and studies on depigmenting creams are limited.[2] A retrospective treatment outcome analysis, at a single center over a 1-year period (June 2018 to June 2019), of patients with melasma receiving oral TA 650 mg daily ± hydroquinone (HQ) 4% cream was performed. This report describes the main clinical characteristics and impact on patients' quality of life (QOL). The primary outcome was the modified Melasma Area and Severity Index (mMASI) score, and impact on QOL was assessed using the Spanish Melasma on Quality of Life questionnaire (Sp-MELASQOL). Patients were evaluated to exclude the risk of thrombosis. The mMASI was calculated by 2 dermatologists blinded to treatment groups. Pearson correlation, paired *t* test, and unpaired *t*-test with Welch's correction were used. A *P* value of less than .05 was considered statistically significant.

Fifty-three patients' charts with sufficient documentation on progress and the degree of improvement at weeks 8 and 20 were included. The main background clinical characteristics are summarized in Table I. Twenty-seven patients (50.94%) received oral TA 650 mg daily (mean baseline mMASI score, 8.25), and 26 (49.05%) received oral TA 650 mg daily plus HQ 4% cream (mean baseline mMASI score, 8.20). At week 20 of treatment, there was a 46% reduction in mMASI score in the TA group versus 61% in the TA plus HQ 4% cream group; this difference was significant ($P = .048$). Mild adverse effects to TA were reported in 7 patients. Notably, there was a 49% reduction in the Sp-MELASQOL score in the combined group compared with 29% with oral TA alone. The overall clinical response rate observed aligns with that reported in previous studies. Zhu et al,[3] in a randomized study, reported no significant differences in the MASI and melanin index among 500; 750; 1,000; or 1,500 mg oral TA. Del Rosario et al,[2] in a randomized study of 39 patients taking 250 mg TA twice daily, reported a 49% reduction in mMASI score compared with 18% in the control placebo group. To our knowledge, this is the first treatment outcome analysis among Hispanic patients. Our data indicated that combined therapy appears superior to oral TA alone. Padhi and Pradhan reported a more significant improvement in MASI score with oral TA 250 mg twice daily in conjunction with a triple combination depigmented cream compared with the triple combination alone,[4] and Karn et al,[5] in a prospective randomized controlled trial, found a significantly higher clinical improvement with oral TA 250 mg twice daily combined with topical HQ versus topical HQ alone. Our data support the use of oral TA plus HQ 4% as a combined therapy for moderate to severe melasma with better clinical and QOL results.

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Table I. Background clinical parameters and treatment outcomes (N = 53)

Characteristics	Value
Sex, n (%)	
Male	2 (3.77)
Female	51 (96.22)
Skin phototype	
II	2 (3.77)
III	22 (41.50)
IV	24 (45.28)
V	5 (9.43)
Age at onset, y	
Mean ± SD	33.5 ± 8.2
Minimum, maximum	17, 50
Years of melasma before starting oral TA	
Mean ± SD	11.03 ± 8.4
Minimum, maximum	1, 36
Clinical parameters	
Main affection, n (%)	
Centrofacial	28 (52.83)
Malar	19 (35.84)
Mandibular	6 (11.32)
Melasma Severity Score, n (%)	
Mild (mMASI of 2.7-4.9)	5 (9.43)
Moderate (mMASI of 5-7.2)	20 (37.73)
Severe (mMASI of 7.3 or more)	28 (52.83)

Treatment outcomes	mMASI	Sp-MELASQOL
Group: 650 mg TA daily		
Baseline	8.25	36.88
Week 8	6.51	—
Week 20	4.4	26.2
Group: 650 mg TA + HQ 4% daily		
Baseline	8.20	32.80
Week 8	5.57	—
Week 20	3.12	16.69
Adverse effects to TA (n = 7), n		
Breast pain	4	
Abdominal pain/inflammation	1	
Arthralgias	1	
Hypo-oligomenorrhea	1	

HQ, Hydroquinone; *mMASI*, Modified Melasma Area and Severity Index; *Sp-MELASQOL*, Spanish-language Melasma Quality of life; *TA*, tranexamic acid.

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Characterizing index keratinocytic carcinomas in commercially insured adults younger than age 50 years in the United States

To the Editor: More than 3 million people are affected by keratinocyte carcinomas (KCs) in the United States, an often-cited estimate from Medicare claims and population survey data for patients 65 years old and older.[1] However, less is known about KCs in younger populations. In this retrospective cohort study, we used health administrative claims data to characterize index KC in commercially insured adults aged 18 to 50 years.

We interrogated the IBM MarketScan Commercial Database, a claims database containing 20 to 40 million US employees (2011-2017), using a previously validated algorithm[2] pairing International Classification of Diseases diagnosis codes with Current Procedural Terminology procedural codes to identify index KC. Enrollees (aged 18-50 inclusive) with 12-months continuous enrollment prior to their index service date were captured. Enrollees with any prior malignancy history of the lip or skin;