



TOPICAL ANTI-ACNE GEL CLINDAMYCIN WITH BENZOYL PEROXIDE AND ORAL DOXYCYCLINE

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Abstract: Progressive macular degeneration hypomelanosis (PMH) is a type of pr - retained dyschromia , which affects mainly young people, nyh skin phototypes , young women are more often affected. One of the etiologic - skih factors depigmentation counts dissemination Propionibacterium asnes , which produces a hypothetical hypopigmenting factor. Also The theory of reduced melanogenesis was proposed because it was described cases recovery pigment after monotherapy UFO 311-312 nm .

Key words: Treatment, prevention

Introduction: The clinical picture of PMG is not specific and is similar to that of - howl with keratomycosis or white lichen. The skin is mainly affected upper body and proximal extremities. Extremely rare the rash spreads to the distal parts of the extremities, neck, scalp you. The rashes are presented as nummular hypopigmented spots a- we, there is no peeling. Subjective sensations (itching, soreness) are not are bothering, there are no signs of previous inflammation. Usually the disease lasts for decades, slowly progressing or without changes, and the disease itself standing permitted after middle age.

Histologically PMG characterized by decrease pigment V epidemi r - while maintaining normal dermal structure. Electron micro- scopy revealed shift from large melanosomes V normal skin To small, agre - glyzed , membrane-bound

melanosomes in hypopigmented skin. These disorders are specific, which allows differentiating PMG from others hypomelanosis torso, such as How, For example, pityriasis versicolor lichen.

Clinical case. A 20-year-old female patient, phototype 2, presented with complaints on a spreading skin rash. Has been sick for 6 weeks. Six months ago, convenient rash already arose, patient contacted V regional cutaneous-venereological - dispensary, where the diagnosis of multi-colored lichen was confirmed microscopically. Shay And appointed treatment: 1% spray terbinafine, 1% salicylic alcohol. After treatments was observed complete disappearance rashes. Two weeks back appealed To to the attending dermatologist, where a relapse of pityriasis versicolor was diagnosed, however microscopy mushrooms genus *Malassezia* Not revealed. Appointed therapy That-peak terbinafine, tincture of salicylic acid, then systemic itra-conazole And topical clotrimazole brought To progressive expressed- to nomu deterioration clinical paintings And significant distribution rashes.

At the time of examination: on the skin of the chest, neck, abdomen, back, lower back, p l e -whose forearms down to the hands, thighs and buttocks are hypopigmented and depigmented spots incorrect forms diameter from 0.2 to 1,2 cm with a clear edge, in some places merging into larger foci. On the skin of the back isolated small pustules. There is no peeling on the surface of the spots, Besnier's symptom is not detected. Balzer's test is negative. At microscop - yeast cells of the genus *Malassezia* in a pic study in an alkaline solution not detected. When examined under a Wood's lamp, a bright orange -in red glow foci. RMP negative.

Based on the clinical picture, laboratory data and special - The use of new methods of research and analysis of medical literature was set diagnosis: Progressive macular hypomelanosis (PMG).

Most effective methods therapy PMG Today counts fixed topical

combination of clindamycin 1% with benzoyl perox and - house 5%, UV A, oral doxycycline . IN recent pilot The study provides compelling evidence for effective repigmentation in response to treatment with monotherapy with UVR 311-312 nm . The best response to treatment (>90% repigmentation) were obtained on average after 20.9 sessions. Relapses were absent - were observed in 68.7% of patients over an average of 13.2 ± 8.2 months, and a tendency towards exacerbations more often observed V cases recent diseases.

IN ours clinical case to the patient was appointed topical gel With fixed combination clindamycin 1% And benzoyl peroxide 5% 1 once V day pointwise on foci And systemic doxycycline 100 mg V day 14 days. Through 14 days noted absence new rashes, erasure borders foci, insignificant - body recovery pigmentation V foci. Was appointed phototherapy UV At 311 nm 3 times a week, external treatment with a fixed combination of clind a -mycin And benzoyl peroxide V gel continued more 2 months. Patient received- la 20 sessions UFO 311 nm . Dermatosi s fully regressed through 2.5 months

Conclusions. Progressive macular degeneration hypomelanosis is by yourself, V more degrees, cosmetic flaw. Because of difficulties di f -differential diagnostics PMG often Maybe be accepted for resistant To treatment multi-colored lichen, persistent treatment whom antifungal -kovymi by means only aggravates clinical picture. PMG enough meagerly described V modern scientific and medical literature, clinical research efficiency therapy Not controlled, based on m a -scrap quantity observations, V basically limited Asian type skin. Our clinical happening showed necessity differential diag n o -sticks recurrent multi-colored lichen With negative answer on an- thymicotic therapy And PMG. Presented by clinical happening pro d e -monstrated efficiency traditional anti-acne treatments (topical anti- acne gel clindamycin With benzoyl peroxide And oral doxycycline) With subsequent UV IN 311 nm therapy V treatment acquired macular hypomelanosis .

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