

International Clinical Recommendations on Scar Management

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Many techniques for management of hypertrophic scars and keloids have been proven through extensive use, but few have been supported by prospective studies with adequate control groups. Several new therapies showed good results in small-scale trials, but these have not been repeated in larger trials with long-term follow-up. This article reports a qualitative overview of the available clinical literature by an international panel of experts using standard methods of appraisal. The article provides evidence-based recommendations on prevention and treatment of abnormal scarring and, where studies are insufficient, consensus on best practice. The recommendations focus on the management of hypertrophic scars and keloids, and are internationally applicable in a range of clinical situations. These recommendations support a move to a more evidence-based approach in scar management. This approach highlights a primary role for silicone gel sheeting and intralesional corticosteroids in the management of a wide variety of abnormal scars. The authors concluded that these are the only treatments for which sufficient evidence exists to make evidence-based recommendations. A number of other therapies that are in common use have achieved acceptance by the authors as standard practice. However, it is highly desirable that many standard practices and new emerging therapies undergo large-scale studies with long-term follow-up before being recommended conclusively as alternative therapies for scar management. (*Plast. Reconstr. Surg.* 110: 560, 2002.)

The management of hypertrophic scars and keloids is characterized by a wide variety of techniques. Many have been proven through extensive use over the past two decades, but few have been supported by prospective studies with adequate control groups, and in some cases even safety data are lacking. Many new

therapies showed early promise in small-scale trials, but these results have not been repeated in larger trials with long-term follow-up. Judgment of efficacy has further been limited by the difficulty in quantifying change in scar appearance, and by the natural tendency for scars to improve over time. Thus, cutaneous scar management has relied heavily on the experience of practitioners rather than on the results of large-scale randomized, controlled trials and evidence-based techniques.

This article reports a qualitative overview of over 300 published references using standard methods of appraisal and, where studies are insufficient, expert consensus on best practices from an international group with extensive experience and interest in the treatment of scarring. Although focusing primarily on the management of hypertrophic scars and keloids, the recommendations are internationally applicable in a range of clinical situations.

DATA COLLECTION

An initial systematic MEDLINE and EMBASE search (1996 through 2001) took place using the mesh terms “scar treatments,” “surgery,” “silicone gel sheeting,” “intralesional corticosteroids,” “radiotherapy,” “cryotherapy,” “pressure therapy,” and “laser therapy.” In addition, a search on scar evaluation methods took place and all review articles on the management of hypertrophic scars and keloids were accessed in these data-

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bases. A secondary hand search of citations in the accessed articles was also conducted.

The authors provided additional review articles, clinical studies, and recent unpublished data that revealed further useful cited references in English and other languages. Those references providing original data on the efficacy of scar management techniques were graded according to "hierarchy of evidence" methods to reflect the reliability of data.¹⁻³ The drafts of the manuscript were reviewed by the chairman and panel during a series of teleconferences and by e-mail.

CLASSIFICATION

Scar classification schemes need to be as clinically relevant as possible, and the authors have extended standard terminology for this article (Table I).

GRADING SYSTEMS

A number of grading systems have been suggested over recent years.⁴⁻⁷ The most widely used system is the Vancouver Scar Scale,⁸⁻¹⁰ which provides an objective measurement of burn scars and assists prognosis and management. Generic measurement tools and record

TABLE I
Scar Classification

Mature scar—A light-colored, flat scar.
Immature scar—A red, sometimes itchy or painful, and slightly elevated scar in the process of remodeling. Many of these will mature normally over time and become flat, and assume a pigmentation that is similar to the surrounding skin, although they can be paler or slightly darker.
Linear hypertrophic (e.g., surgical/traumatic) scar—A red, raised, sometimes itchy scar confined to the border of the original surgical incision. This usually occurs within weeks after surgery. These scars may increase in size rapidly for 3–6 months and then, after a static phase, begin to regress. They generally mature to have an elevated, slightly rope-like appearance with increased width, which is variable. The full maturation process may take up to 2 years.
Widespread hypertrophic (e.g., burn) scar—A widespread red, raised, sometimes itchy scar that remains within the borders of the burn injury.
Minor keloid—A focally raised, itchy scar extending over normal tissue. This may develop up to 1 year after injury and does not regress on its own. Simple surgical excision is often followed by recurrence. There may be a genetic abnormality involved in keloid scarring. Typical sites include earlobes.
Major keloid—A large, raised (>0.5 cm) scar, possibly painful or pruritic and extending over normal tissue. This often results from minor trauma and can continue to spread over years.

forms have been developed to help use this scale.

PREVENTION OR TREATMENT

It is much more efficient to prevent hypertrophic scars than to treat them. Prevention implies using a therapy with the aim of reducing the risk of a problem scar evolving. The transition to a treatment regimen takes place when a true hypertrophic scar or keloid, and not an immature scar, is diagnosed. Conceptually and practically, treatment and prevention regimens can be similar, and the following section presents the clinical data for both. Early diagnosis of a problem scar can considerably impact the outcome. The consensus of the authors is that the most successful treatment of a hypertrophic scar or keloid is achieved when the scar is immature but the overlying epithelium is intact, although this is not as yet confirmed in current literature.

THERAPIES

A comprehensive review of the clinical literature published over the past 30 years on scar treatments was undertaken and the evidence was graded for quality. An evaluation is presented for each modality. The efficacy of two scar management techniques, silicone gel sheeting and injected corticosteroids, has been demonstrated in randomized, controlled trials.

Comparison between treatment modalities and between clinical studies is difficult, as defining an adequate response to therapy remains a relatively neglected area. A mild partial response, which may still leave a cosmetically unacceptable scar, is accepted as a therapeutic success in most studies. Scars never disappear and in many cases only partial response is possible.

The variability in efficacy and recurrence rates between studies is striking and makes single uncontrolled studies impossible to evaluate. There are some good reasons for this variability. First, differentiating hypertrophic scars from keloids can be problematic. Second, there is a tremendous range between the scar that becomes hypertrophic in the first few months and then completely resolves with little or no treatment and the more severe hypertrophic scar that becomes permanently disfiguring. Length of follow-up, heterogeneity of the scars, and the lack of controls can either overestimate or understate the benefit of treatment, but more often the former. Third, ke-

loids often do not recur for 6 months to as long as 2 years, and so length of follow-up is critical. Very few studies on keloids have adequate follow-up. These limitations must be kept in mind in evaluating any of the therapies below.

Surgery

Surgical excision of hypertrophic scars or keloids is a common management option when used in combination with steroids and/or silicone gel sheeting. However, excision alone of keloids results in a high rate of recurrence (45 to 100 percent).¹¹⁻¹⁴

Combining surgery with steroid injections reduces the recurrence rate of keloids to less than 50 percent, with the combination of surgery and perioperative radiation therapy reducing recurrence to 10 percent.^{11,15} However, this combination approach is usually reserved for abnormal scars resistant to other treatments.

Hypertrophic scarring resulting from excessive tension or wound complications, such as infection or delay in healing, can be treated effectively with surgical excision combined with surgical taping and silicone gel sheeting. Scars that are subject to tension require substantial physical support. The authors agreed that the most effective way of splinting scars is by surgical closure with intradermal sutures for at least 6 weeks and, when tension is substantial, for up to 6 months. Surgical techniques, such as W-plasty and Z-plasty, improve the appearance and mobility of contracted burn scars but are not appropriate for immature hypertrophic scars.¹⁶

Corticosteroid Injections

Despite relatively few randomized, prospective studies, there is a broad consensus that injected triamcinolone is efficacious and is first-line therapy for the treatment of keloids and second-line therapy for the treatment of hypertrophic scars if other easier treatments have not been efficacious.^{15,17-23} Despite their use in scar management since the mid-1960s, their principal mechanism of action remains unclear.^{24,25} Response rates vary from 50 to 100 percent, with a recurrence rate of 9 to 50 percent.¹⁸ Results are improved when corticosteroids are combined with other therapies such as surgery^{11,13,26} and cryotherapy.^{27,28}

Intralesional corticosteroid injection is associated with significant injection pain, even with standard doses of insoluble triamcinolone (40

mg/ml), and up to 63 percent of patients experience side effects that include skin atrophy, depigmentation, and telangiectasias.²⁹ Topical steroid creams have been used with varying success,³⁰ but absorption through an intact epithelium into the deep dermis is limited. A prospective, randomized study shows that topical steroids do not reduce scar formation in postburn deformities.³¹

Silicone Gel Sheetting

Silicone gel sheeting has been a widely used clinical management option for hypertrophic scars and keloids since the early 1980s.³²⁻³⁷ Despite initial skepticism, there is now good evidence of its efficacy and silicone gel sheeting has now become standard care for plastic surgeons. Results from at least eight randomized, controlled trials and a meta-study of 27 trials³⁸ demonstrate that silicone gel sheeting is a safe and effective management option for hypertrophic scars and keloids.³⁹⁻⁴⁸ Totally occlusive dressings (e.g., polyethylene films) and semi-occlusive dressings, such as polyurethane films, have not shown evidence of efficacy, and evidence of the effectiveness of other materials such as glycerin and other non-silicone-based dressing is mixed.⁴⁹⁻⁵¹

Silicone gel sheeting may be especially useful in children and others who cannot tolerate the pain of other management procedures. Silicone products vary considerably in composition, durability, and adhesion. To date, most conclusive trials have been undertaken on pure adherent silicone gel sheeting. It is not known whether these results are transferable to other fabric/polyurethane dressings with silicone adhesive or to nonadherent silicone products.⁵² Some formulations of silicone oil have been shown to be effective on minor hypertrophic scars, although these studies have limitations in their design.^{33,53}

Pressure Therapy

Pressure therapy has been used in the management of hypertrophic scars and keloids since the 1970s.⁵⁴ It has been standard therapy for hypertrophic burn scars and is still first-line therapy in many centers.⁵⁵⁻⁶¹

It is generally recommended that pressure be maintained between 24 and 30 mmHg for 6 to 12 months for this therapy to be effective; however, this advice is largely empiric.^{18,62} There are mixed reports on long-term compliance, but it remains a significant issue, as ef-

fectiveness seems to be related directly to the duration of pressure.⁶³⁻⁶⁵

The evidence supporting the speed of scar maturation and enhancement of cosmetic outcome is variable. For example, in a prospective randomized study in 122 burn patients, pressure garments did not increase the speed of wound maturation or decrease the duration of hospital stay.⁶⁶

Radiotherapy

Radiotherapy has been used as monotherapy, and in combination with surgery, for hypertrophic scars and keloids. However, monotherapy remains controversial^{15,67} because of anecdotal reports of carcinogenesis following the procedure. Response to radiotherapy alone is 10 to 94 percent, with a keloid recurrence rate of 50 to 100 percent.^{11,13} Such high recurrence rates are understandable, given the resistance of these cases to other management options. Best results have been achieved with 1500 to 2000 rads over five to six sessions in the early postoperative period.^{68,69} There have been mixed results from radiotherapy after surgical excision of keloids, with a significant objective response reported in 25 to 100 percent of patients.^{18,70,71}

Radiotherapy is difficult to evaluate, as most studies are retrospective, do not define the term "recurrence," and use a variety of radiation techniques with varying follow-up (6 to 24 months). In addition, there are no randomized, prospective studies with long-term follow-up. Most investigators agree that radiotherapy should be reserved for adults and keloids resistant to other management modalities. Nevertheless, radiotherapy with informed consent remains a valuable therapeutic option and is the most efficacious treatment available in severe cases of keloids, provided there is appropriate shielding of nonaffected tissues.

Laser Therapy

Laser therapy has been used for nonspecific destruction of tissue to produce less scarring, but this has been largely discredited following mixed results in larger long-term trials with carbon dioxide and argon lasers. Carbon dioxide lasers showed early promise in the excision of keloids⁷² but failed to suppress keloid growth and recurrence in later studies.^{73,74}

Two newer types of carbon dioxide laser are in use. Small noncontrolled studies, limited by lack of long-term follow-up, suggested that

high-energy short-pulsed carbon dioxide lasers and scanned continuous-wave carbon dioxide lasers were effective in postsurgical hypertrophic/keloidal, traumatic, acne, and varicella scars.^{75,76} Scanning carbon dioxide lasers have been used to debride burn wounds, but without clinically improved scar outcome.⁷⁷ However, these early reports have not been widely substantiated, and currently carbon dioxide laser is not widely accepted for the treatment of keloids because of the high late recurrence rates.

Argon lasers were first used in the 1970s for the management of keloids, but studies failed to show long-term improvements.^{73,78} They produce more nonspecific thermal damage than carbon dioxide lasers and are associated with higher levels of keloid recurrence.⁷⁶

More recent wavelength-specific lasers (yttrium-aluminum-garnet and pulsed-dye lasers) have been used to selectively ablate blood vessels. Neodymium:yttrium-aluminum-garnet lasers have response rates between 36 and 47 percent.⁷⁹ In a recent study of 17 patients with keloids, nearly 60 percent of keloids were flattened following one session of neodymium:yttrium-aluminum-garnet laser treatment. These patients remained free of keloid scarring at 18-month to 5-year follow-up.⁸⁰ The remaining seven patients required further laser treatment and intralesional corticosteroids to flatten the keloids completely. Recurrence of keloids occurred in three patients, all of whom responded to further laser treatment. A recent study in 36 patients has shown that the pulsed erbium:yttrium-aluminum-garnet laser is an effective and safe treatment option for hypertrophic and depressed scars.⁸¹ Further large comparative studies with longer follow-up are now required.

Flashlamp-pumped pulsed-dye lasers have shown promise in elimination of erythema and flattening atrophic and hypertrophic scars.⁸²⁻⁸⁵ Intense-pulsed-light-source devices are usually considered in the same category as pulsed-dye lasers. Improvements in appearance of hypertrophic scars and keloids have been noted in 57 to 83 percent of cases,⁸² with further improvements seen in combination with intralesional corticosteroids.⁸⁶ A pilot study has suggested that laser treatment in combination with intralesional corticosteroids is effective in healing previously resistant keloids.⁸⁷ A recent study in 106 patients (171 anatomic sites) has shown fast resolution of scar stiffness and ery-

thema and improvement in quality of scarring when preventive treatment with flashlamp-pumped pulsed-dye lasers is started within 2 weeks after surgery.⁸⁸ However, a recent single-blind, randomized, controlled study in 20 patients with hypertrophic scars showed no improvements in hypertrophic scars following laser therapy.⁸⁹ Laser therapy remains emerging technology, with limited follow-up and a lack of controlled studies. Further studies are required to define its role. However, many dermatologists, and some of the authors, have seen benefits in erythematous hypertrophic scars in speeding resolution, and perhaps improving long-term outcomes.

Cryotherapy

Cryotherapy alone results in keloid flattening in 51 to 74 percent of patients after two or more sessions, and it is beneficial for the management of severe acne scars.⁹⁰⁻⁹³ Limitations include the delay of several weeks required for postoperative healing and the commonly occurring side effect of permanent hypopigmentation. Other side effects include hyperpigmentation, moderate skin atrophy, and pain.⁹⁴ As a result, cryotherapy is generally limited to management of very small scars.

Adhesive Microporous Hypoallergenic Paper Tape

The consensus of the authors was that applying paper tape with an appropriate adhesive to fresh surgical incisions, and for several weeks after surgery, was useful. The mechanism of benefit is unknown, but may in part be mechanical (analogous to pressure therapy) and occlusive (analogous to silicone gel therapy). However, only two uncontrolled studies confirm its efficacy.^{95,96} The authors also felt that this treatment was less effective than more established treatments such as silicone gel, but it could be used as preventive treatment in low-risk patients, or before silicone gel use in fresh incisions. Tape with an elastic component may be useful for scars over mobile or complex surfaces, including joints.

Miscellaneous Therapies

There are anecdotal reports on a number of additional therapies, but there is no adequate published information on which the authors can evaluate the efficacy and safety of these therapies or make recommendations. These therapies fall into three categories.

The first category includes popular treat-

ments that have an absence of randomized studies or some negative studies suggesting lack of efficacy. These include topical vitamin E,^{31,97,98} onion extract cream,⁹⁹ allantoin-sulfomucopolysaccharide gel,^{100,101} glycosaminoglycan gel,¹⁰² and creams containing extracts from plants such as *Bulbine frutescens* and *Centella asiatica*.¹⁰³

The second category includes classic therapies with anecdotal success but significant side effects or lack of confirming studies. These include topical retinoic acid,¹⁰⁴ colchicine,¹⁰⁵ and systemic antihistamines.¹⁰⁶

The third category includes newer therapies with anecdotal reports that do not yet have a history. Although these may develop into useful therapies in the future, the authors cannot make any recommendations at this time. These include skin equivalents that incorporate artificial dermis constructs, cyclosporine,¹⁰⁷ and intralesional verapamil.¹⁰⁸

Other physical management options include hydrotherapy, massage, ultrasound, static electricity, and pulsed electrical stimulation. Hydrotherapy is widely used in several European countries for the treatment of hypertrophic burn scars (using high pressure). Massage has been widely used by physical therapists, occupational therapists, and other allied health care professions. However, further long-term studies are required before recommendations can be made regarding their efficacy.

Emerging Evidence

Three therapies provide emerging evidence of efficacy:

- Interferon (interferon- α , interferon- β , and interferon- γ)¹⁰⁹⁻¹¹⁵
- Intralesional 5-fluorouracil^{115,116}
- Bleomycin injections¹¹⁷⁻¹²⁰

Interferon- α , interferon- β , and interferon- γ have been shown to increase collagen breakdown.¹⁰⁹⁻¹¹¹ Tredget et al. found that interferon- α 2b injections three times weekly resulted in significant mean rates of improvement of hypertrophic scars versus control and also reduced serum transforming growth factor- β levels that continued after treatment.¹¹⁴ Interferon injections are reported to be significantly better than triamcinolone acetonide injections in preventing postsurgical recurrence of keloids (18.7 percent versus 58.5 percent recur-

rence).¹¹⁵ However, these painful injections may require regional anesthesia.

Intralesional 5-fluorouracil has been used successfully as monotherapy as well as in combination with intralesional corticosteroids to treat hypertrophic scars and keloids.^{15,116} Physicians experienced in its use show great enthusiasm for 5-fluorouracil. The rationale for its use is sound, and it shows a lack of side effects. It may warrant further investigation and wider use as an alternative to steroid injections in difficult-to-treat patients.

Bleomycin injections show evidence of efficacy in managing surgical/traumatic hypertrophic scars.^{117,118} Patients with older scars resistant to intralesional corticosteroids showed good response to bleomycin 0.01% injections every 3 to 4 weeks. A recent pilot study in 13 patients showed complete flattening (six patients) or significant flattening (>90 percent; six patients) of hypertrophic scars and keloids following administration of bleomycin (1.5 IU/ml) using a multiple-puncture method on the skin surface.¹¹⁹ Although published research is limited, there is considerable clinical experience in using this modality in some European countries. The rationale for use of bleomycin, which is another chemotherapeutic agent, is similar to that of 5-fluorouracil. A comparative study of the two agents with steroids is warranted. Adverse effects have not been reported for this indication, although side effects in the treatment of warts with bleomycin include nail loss and Raynaud's phenomenon.^{120,121}

Bleomycin and intralesional 5-fluorouracil have been used by some of the authors with considerable success. Despite a strong theoretical rationale, larger scale prospective studies with appropriate follow-up are needed before these treatments can be considered as standard therapy.

In addition, experimental animal studies suggest that there may be a role for transforming growth factor modulators.¹²²⁻¹²⁵ Transforming growth factor- β has been implicated in several scarring conditions including pulmonary fibrosis, glomerulonephritis, and cutaneous scarring. There are three isoforms, and there is some evidence that the ratio is critical for optimizing scar outcome. In addition to blocking transforming growth factor- β effects with antibodies, researchers have proposed blocking transforming growth factor- β activation by means of the mannose 6-phosphate receptor,

and adding the transforming growth factor- β isoform. These approaches have shown efficacy in animal models.¹²⁵⁻¹²⁷ Early human trials are in progress for some of these strategies.

Another area of active research is interference with collagen synthesis. Historically, penicillamine and other nonspecific inhibitors of collagen synthesis were used as inhibitors, but they showed unacceptable toxicity. In recent years, several companies have looked for specific nontoxic inhibitors of collagen synthesis that could be applied locally. Animal trials have been promising.¹²⁸ Overall, there has been a substantial effort in the pharmaceutical and biotechnology industry to develop more effective antiscarring therapies, and it seems likely that new therapies will be available within the next 5 years.

RECOMMENDATIONS

These recommendations are made primarily on the basis of the clinical evidence reviewed above and reflect the practice of the authors and have been summarized in simple management algorithms (Figs. 1 and 2). Cost-effectiveness of therapies is not assessed in this article.

Prevention

Every effort must be made to prevent the development of hypertrophic scars or keloids after surgery or trauma. Excellent surgical technique and efforts to prevent postsurgical infection are of prime importance.¹²⁹ Special attention should be given to high-risk patients (i.e., those who have previously suffered abnormal scarring or are undergoing a procedure with a high incidence of scarring, such as breast and thoracic surgery). To our knowledge, there has been no large-scale assessment of scar outcomes and risk factors. Recommended preventive techniques include the following:

- Hypoallergenic microporous tape with elastic properties to minimize the risk from shearing. Use of taping for a few weeks after surgery is standard practice for the majority of the authors. Although there are no prospective controlled studies documenting its efficacy, the authors' consensus is that it is beneficial.
- Silicone gel sheeting, which should be considered as first-line prophylaxis. Use of silicone gel sheeting should begin soon after surgical closure, when the incision has fully

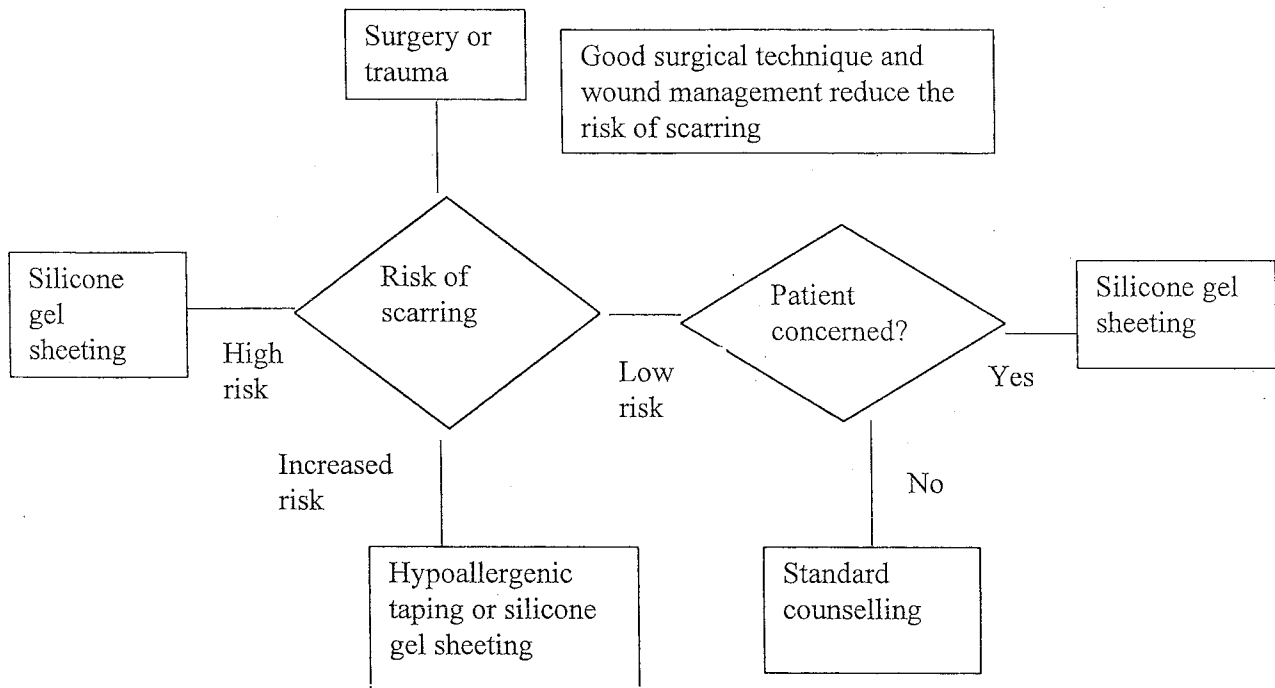


FIG. 1. Prevention of surgical/trauma scarring.

epithelialized, and be continued for at least 1 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. Use of silicone ointments may be appropriate on the face and neck regions, although their efficacy in preventing scarring is unsupported by controlled trials.

- Concurrent intralesional corticosteroid injections as second-line prophylaxis for more severe cases.

The effectiveness of alternative therapies is limited to anecdotal evidence. Patients at low risk of scarring should maintain normal hygiene procedures and be provided with counseling and advice if concerned about their scar.

Scar Classification and Patient History

When patients present with a troublesome scar, appropriate therapy should be selected on the basis of scar classification and patient history. Scar classification is the primary decision criterion for treatment selection. Patient history, however, provides important information about the risk of the scar worsening should treatment fail, about previous therapies, and about the patient's likely compliance. The degree of erythema has been identified as being of great importance in predicting the activity of the scar and response to therapy.

Associated Symptoms

Pain and itchiness are commonly reported symptoms associated with scarring. Evidence of management methodologies for pruritus remains anecdotal. Pulsed-dye lasers may have value in reduction of itching, although more cost-effective options are preferred at this stage. Other treatments, such as moisturizers, silicone gel sheeting, systemic antihistamines, topical corticosteroids, antidepressants, massage, and hydrotherapy have been shown to improve symptoms. Care should be taken with hypersensitivity to moisturizing products such as lanolin.

Management

Immature hypertrophic scars (red). It is often difficult to predict whether this type of scar will resolve or develop into a hypertrophic scar. In the authors' experience, the techniques described above in the Prevention section should be followed. If erythema persists for more than 1 month, the risk of true hypertrophy increases and management should be as for a linear or widespread hypertrophic scar as appropriate (see below). These scars may benefit from a course of pulsed-dye laser therapy, although this therapy requires further long-term trials.

Linear hypertrophic (surgical/traumatic) scars (red, raised). Silicone gel sheeting should be

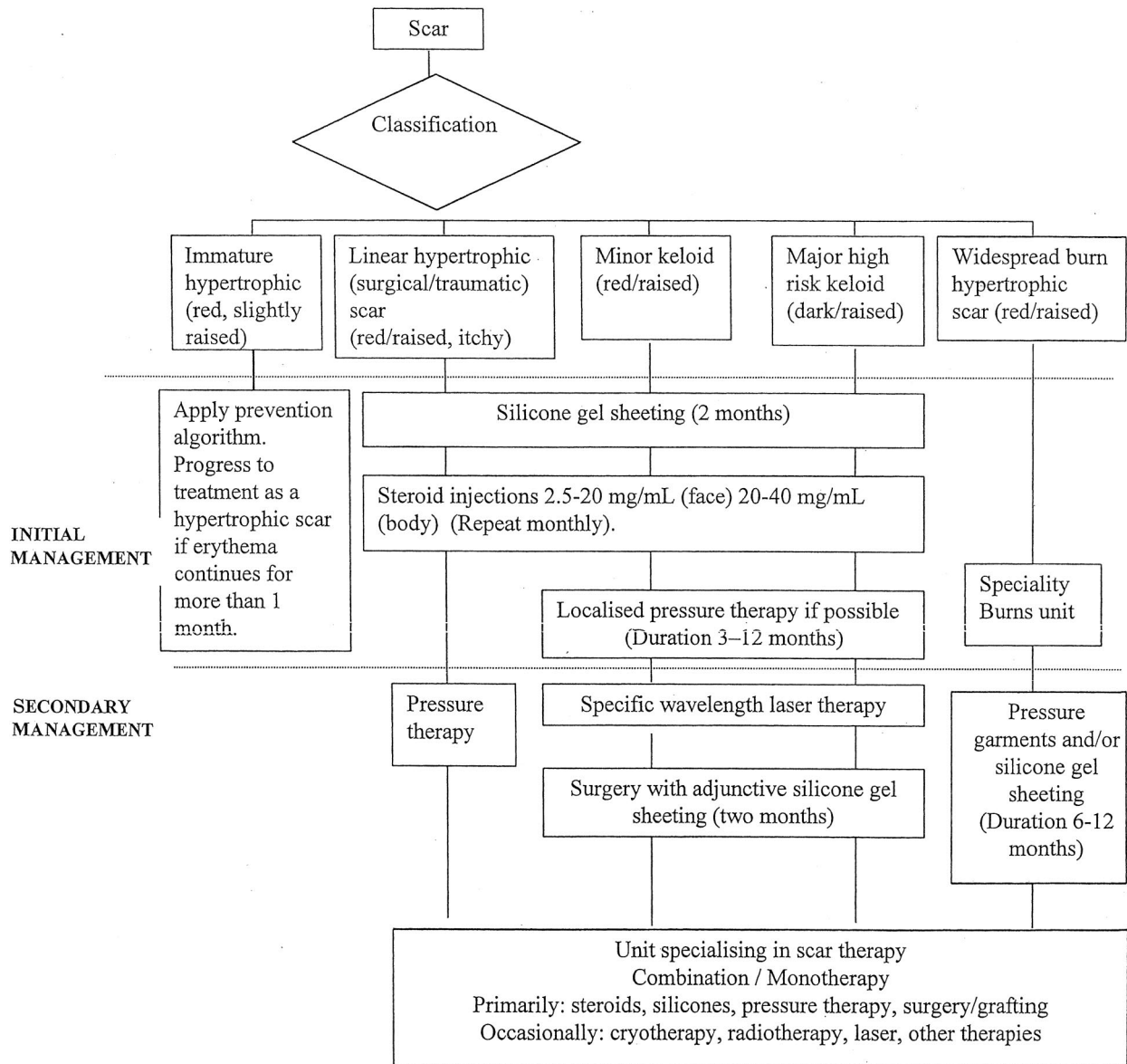


FIG. 2. Complete management algorithm.

used as first-line therapy, in line with results from randomized, controlled trials. If the scar is resistant to silicone therapy, or the scar is more severe and pruritic, further management with corticosteroid injections is indicated. Additional consideration may be given to other second-line therapies mentioned above for severe cases.

If silicone gel sheeting, pressure garments, and intralesional corticosteroid injections are not successful after 12 months of conservative therapy, surgical excision with postoperative application of silicone gel sheeting should be considered. An option for more severe scars is reexcision with layering of triamcinolone ace-

tonide, long-term placement of intradermal sutures, and subsequent corticosteroids. Specific-wavelength laser therapy and cryotherapy have been used by the authors but require further controlled studies.

Widespread burn hypertrophic scars (red/raised). Widespread burn scars should be treated with first-line therapy of silicone gel sheeting and pressure garments, although there remains limited significant evidence for the efficacy of pressure garments. The treatment of burn scars is difficult and often requires a combination of techniques including individualized pressure therapy; massage and/or physical therapy; silicone gel sheeting; corticosteroids on particu-

larly difficult areas; and surgical procedures such as Z-plasty, excision, and grafting or flap coverage. A variety of adjunctive therapies such as massage, hydrocolloids, and antihistamines to relieve pruritus are also used. Pulsed-dye laser may have a role.

Minor keloids. The consensus view from the literature and the authors is that first-line therapy for most minor keloids is a combination of silicone gel sheeting and intralesional corticosteroids. If there is no resolution, surgical excision with follow-up intralesional steroids and silicone gel sheeting is indicated. Localized pressure therapy such as ear clips on earlobe keloids has been shown to be helpful as second-line adjunctive therapy in small trials.

Surgical excision without careful follow-up or use of other adjunctive measures will result in a high recurrence rate, and if the surgery is performed without careful attention to preserving normal architecture, the resulting deformity after recurrence may be worse. It is preferable to only partially excise the keloid rather than produce a deformity. The authors' experience is that excision of difficult recurrent keloids with grafting of skin taken from the excised keloid followed by immediate radiation therapy can be successful, but that the long-term risks of radiation must be carefully weighed.

Major keloids. Major keloids are a most challenging clinical problem, and many are resistant to any treatment. Extensive counseling with the patient is required before embarking on a surgical solution because the recurrence rate is so high. For some patients, symptomatic treatment with antihistamines and good hygiene may be all that is possible. Radiation therapy should be considered for treatment failures, and innovative therapies such as bleomycin and 5-fluorouracil may have a future role, in addition to investigational strategies that interfere with transforming growth factor- β or collagen synthesis. These patients are best treated by clinicians with a special interest in keloids. Ongoing patient counseling and advice on prevention are essential components of this therapy.

CONCLUSIONS

Management choices should depend on the patient's individual requirements and evidence-based findings. There remains a significant need for further randomized, controlled trials of all available scar therapies and system-

atic, quantitative reviews of the literature to ensure optimal management of scarring. The authors' recommendations are made on the basis of the best available evidence in the literature, particularly randomized, controlled trials, supported by clinical experience. Many management techniques have limited data to support their use, and these recommendations support a move to a more evidence-based approach in scar management.

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