

BRIEF ARTICLE

Sealing the Deal: Embracing Hydrocolloid Dressings for Post Procedure Dermatologic Care

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ABSTRACT

Hydrocolloid dressings provide a maintenance-free method of post-procedural wound care. Commercially available hydrocolloid dressing, however, may not be accessible or affordable for all procedural patients. Here we report a case of a patient with a fibroepithelioma of pinkus treated with electrodesiccation and curettage with post-procedural wound care managed with an over-the-counter hydrocolloid “pimple” patch.

INTRODUCTION

Hydrocolloid dressings provide a maintenance-free method of post-procedural wound care for dermatology patients undergoing surgical treatment for skin cancer.^{1,2} Commercially available hydrocolloid dressing (HD) can provide improved comfort, convenience, and cosmesis compared to traditional wound care dressing (WCD) but may not be accessible or affordable for all patients.^{1,2} Here we present the use of over-the-counter (OTC) Neutrogena Stubborn Acne Ultra-Thin Blemish Patch Triangles (Neutrogena, Los Angeles, CA) as an affordable alternative for maintenance-free dressings following non-melanoma skin cancer (NMSC) treated with electrodesiccation and curettage (ED&C).

CASE REPORT

A 53-year-old man presented for an evaluation of a 1.3-cm by 1.0-cm

erythematous nodule on the left lateral mid-back which on histopathology returned as a basal cell carcinoma, sub-type fibroepithelioma of Pinkus. Treatment options were discussed with the patient including wide local excision (WLE) and ED&C. Patient was amenable to ED&C and, on follow up, post-biopsy site (**Figure 1A**) was treated with 3 rounds of curettage followed by electrodesiccation without complications. After the first round of curettage, the wound dimensions were 1.2-cm by 1.2-cm (**Figure 1B**). On completion of ED&C, a large triangular acne hydrocolloid dressing (aHD) was placed over the procedural site (**Figure 1C**) and the patient was advised to keep the dressing on until follow up 1 week later.

On post-procedure day 7, the aHD remained in place and the procedural site had notable central fibrinous material and granulation tissue and a surrounding area of triangle-shaped erythema without any pruritus (**Figure 2**). Patient was advised to place a new aHD over the affected area and again follow up in 1 week. On post-procedure day

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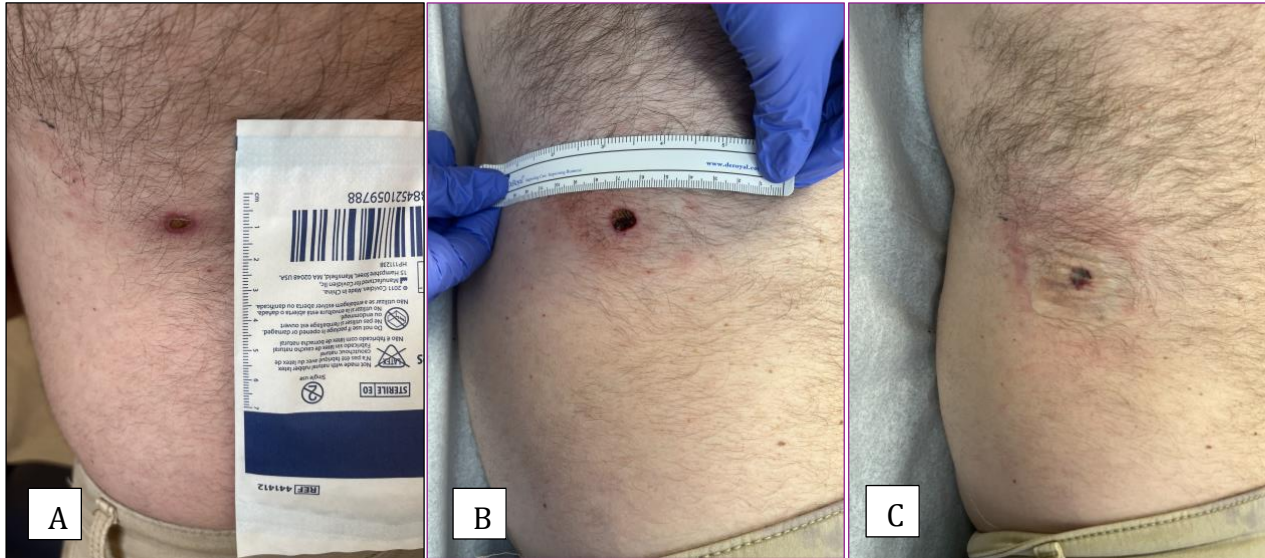


Figure 1. Fibroepithelioma of Pinkus prior to (A), immediately following electrodesiccation and curettage (B), and dressing with acne hydrocolloid dressing (C).



Figure 2. Post-procedural follow-up 1 week after electrodesiccation and curettage. Procedural site marked with granulation tissue, mild maceration, and asymptomatic perilesional erythema. Patient advised to wear acne hydrocolloid dressing for additional week.

14, central procedural area had complete granulation with mild persistence of asymptomatic triangular-shaped surrounding erythema (**Figure 3**). Patient was advised to

discontinue aHD and follow up within 3 months for next full body skin exam.

DISCUSSION

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Figure 3. Two-week post-procedural follow up. Procedural site well-healed with granulation tissue and persistence of surrounding asymptomatic erythema. Patient advised to discontinue acne hydrocolloid dressing after this visit.

As the incidence of non-melanoma skin cancers continues to increase, so too will the number of procedures and patients requiring post-procedural wound care.³ Prior studies have found significant heterogeneity in post-procedural instructions while others have found mixed data regarding optimized dressings.^{4,5} Combined with patients who either live alone, are of older age, or with limited mobility, these factors may increase post-procedural morbidity for patients managing post-procedural sites.⁵ Although outcomes regarding surgical site infection and scarring have presented mixed results⁴, smaller randomized-controlled trials have found significant difference in patient satisfaction utilizing hydrocolloid dressings following dermatologic surgery.² Compared to conventional daily dressing, patients

favor hydrocolloid dressing due to numerous factors including convenience, comfort, scar appearance, and simplicity of wound care instructions.

Limiting factors regarding traditional hydrocolloid dressings relative inaccessibility and cost. Traditional, commercial HD are often not available in retail pharmacies; furthermore, online HD may cost nearly \$8/dressing.⁶ Alternatively, the aHD are readily available in most retail/chain pharmacies and currently cost ~\$2/dressing.⁷ Taken together, aHD may be an accessible, suitable alternative for post-operative, maintenance-free wound care of NMSC managed with ED&C, especially for older patients with limited mobility or on areas (e.g.

back) where they may not be able to perform a dressing change without assistance.

Here we demonstrate the successful application of aHD for post-procedural, maintenance-free wound care of a truncal NMSC following ED&C. Possible adverse effects include maceration and (allergic) contact dermatitis (e.g., colophony). In our case, patient may have had reportedly asymptomatic erythema surrounding the procedure site which may have been irritation from the adhesive or an early contact dermatitis, which ultimately self-resolved.

CONCLUSION

Maintenance-free dressings with (a)HD provides a convenient and accessible method for post-procedural wound care for NMSC patients. Over-the-counter thin hydrocolloid patches marketed for acne may serve as a cheap, durable, and effective alternative for post-ED&C care on the trunk.

Conflict of Interest Disclosures: None

Funding: None

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