Navigating risks and complications of cosmetic resurfacing procedures.

Sifen Dong*

Division of Plastic Surgery, University of California Davis Medical Center, USA

Introduction

Cosmetic resurfacing procedures, including chemical peels, microneedling, laser therapies, and dermabrasion, have gained popularity for their ability to enhance skin appearance by treating pigmentation issues, acne scars, and signs of aging. However, alongside their benefits, these treatments also come with potential risks and complications. Understanding these is essential for patients and practitioners to ensure safe and effective outcomes [1].

Cosmetic resurfacing involves the removal or stimulation of skin layers to promote collagen production, cell turnover, and rejuvenation. Techniques vary in intensity and depth, ranging from mild superficial peels to deeper ablative laser treatments. While advancements in dermatological technology have minimized some risks, complications still occur due to skin type, incorrect technique, or poor post-treatment care [2].

PIH is a frequent complication, especially in individuals with darker skin types. It occurs due to increased melanin production following inflammation and is often seen after aggressive treatments. Scarring can result from improper technique, infection, or patient factors like keloid-prone skin. Deep chemical peels and ablative laser resurfacing carry higher scarring risks [3].

Cosmetic resurfacing disrupts the skin barrier, increasing susceptibility to bacterial, viral (e.g., herpes simplex), or fungal infections. Preventive antiviral therapy is often recommended, especially for laser treatments. Redness may persist for weeks or even months post-treatment. This side effect is more common with deeper resurfacing and can be distressing for patients [4].

Chemical agents used in peels can trigger allergic reactions or dermatitis, particularly when applied improperly or to sensitive skin types. Uneven skin texture, enlarged pores, and skin atrophy can occur if resurfacing is too aggressive or healing is impaired [5].

When treatment areas don't blend smoothly into surrounding skin, noticeable lines or color mismatches can develop. Although mild discomfort is expected, prolonged pain may signal underlying issues such as nerve damage or infection [6].

Risk Factors Influencing Complications Several factors increase the likelihood of complications: Types IV–VI are more prone to PIH and scarring. Rosacea, eczema, and acne can worsen post-procedure. UV exposure during

healing exacerbates hyperpigmentation and delays recovery. Untrained or inexperienced practitioners significantly increase complication risks [7].

Evaluate patient history, skin type, and contraindications. Consider preconditioning regimens with topical agents like hydroquinone to reduce PIH risk. Emphasize the importance of sun protection, adherence to aftercare instructions, and signs of complications [8].

Use of emollients, sunscreen, and prescribed antibiotics or antivirals when necessary. For high-risk individuals, less aggressive treatments at multiple intervals are safer than a single deep procedure. Emerging Solutions and Safety Innovations Technological innovations aim to reduce complications [9].

These deliver energy in microscopic columns, allowing quicker healing and reduced risk of PIH and scarring. This combines microneedling with radiofrequency energy for deeper collagen remodeling with minimal surface damage [9].

Personalized chemical formulations based on patient skin type and needs help minimize adverse reactions. While cosmetic resurfacing can dramatically improve skin appearance, it carries inherent risks that require careful management [10].

Conclusion

A thorough patient assessment, proper technique, and attentive post-care are essential to minimize complications. Awareness of potential adverse effects not only empowers patients to make informed decisions but also fosters safer dermatological practices. Ongoing research and technological advances will continue to refine these procedures, offering improved safety and efficacy for diverse skin types.

References

- 1. Antille C, Tran C, Sorg O, et al. Penetration and metabolism of topical retinoids in ex-vivo organ-cultured full-thickness human skin explants. Skin Pharmacol Physiol. 2004;17:124–8.
- 2. Astrom A, Tavakkol A, Pettersson U, et al. Molecular cloning of two human cellular retinoic acid-binding proteins (CRABP). J Biol Chem. 1991;266:17662–6.
- 3. Bhawan J, Olsen E, Lufrano L, et al. Histologic evaluation of the long-term effects of tretinoin on photodamaged skin. J Dermatol Sci. 1996;11:177–82.

 $\textbf{*Correspondence to:} \ Sifen \ Dong, \ Division \ of \ Plastic \ Surgery, \ University \ of \ California \ Davis \ Medical \ Center, \ USA. \ E-mail: \ dongs@ucdavis.edu$

Received: 03-Apr-2025, Manuscript No. AADRSC-25-163872; Editor assigned: 04-Apr-2025, PreQC No. AADRSC-25-163872(PQ); Reviewed: 17-Apr-2025, QC No AADRSC-25-163872; Revised: 22-Apr-2025, Manuscript No. AADRSC-25-163872(R); Published: 28-Apr-2025, DOI:10.35841/aadrsc-9.2.257

Citation: Dong S. Navigating risks and complications of cosmetic resurfacing procedures. Dermatol Res Skin Care. 2025; 9(2):257

- 4. Diridollou S, Vienne MP, Alibert M, et al. Efficacy of topical 0.05% retinaldehyde in skin aging by ultrasound and rheological techniques. Dermatol. 1999;199:37–41.
- 5. Fisher GJ, Datta SC, Talwar HS, et al. The molecular basis of sun induced premature ageing and retinoid antagonism. Nature. 1996;379:335–8.
- 6. Lyell A. The itching patient. A review of the causes of pruritus. Scot Med J. 1972;17(10):334–37.
- 7. Weisshaar E, Apfelbacher C, Jäger G, et al. Pruritus as a leading symptom: Clinical characteristics and quality

- of life in German and Ugandan patients. Br J Dermatol. 2010;155(5):957–964.
- 8. Gu H, Chen XS, Chen K, et al. Evaluation of diagnostic criteria for atopic dermatitis: Validity of the criteria of Williams et al in a hospital-based setting. Br J Dermatol. 2001;145:428–33.
- 9. Kim JS. Pediatric atopic dermatitis: The importance of food allergens. Semin Cutan Med Surg. 2008;27:156–60.
- 10. Bird JA, Crain M, Varshney P. Food allergen panel testing often results in misdiagnosis of food allergy. J Pediatr. 2015;166(1):97–100.