

Editorial

Keloids: how should they be managed?

Keloids are due to an abnormal wound healing response in which there is overgrowth of fibrous tissue beyond the edges of the wound following injury to the skin. These can often be painful or itchy and, depending on the site and size, these can also pose cosmetic problems and psychological distress. There is a higher risk of keloid formation in patients under 30 years of age with the cheeks, chest, earlobes, shoulders and upper arms being more prone to keloid formation.¹ The true prevalence of keloids is unknown, but has been reported to be more common in Africans and Asians (5 to 16%)^{2,3} and an annual incidence of keloids in Taiwan has been reported as 15/10,000.⁴ It has also been reported that Chinese patients are more prone to keloid formation than Malaysian or Indian patients.⁵

If extensive, such as after burns, keloids can result in restriction of movement, especially if located near a joint. Research has shown that pain and pruritus from keloids and hypertrophic scarring correlates with physical impairment and both pain and restriction of movement have been shown to have an adverse psychological effect.⁶ Treatment of keloids is therefore important but difficult. However, there are no formal trials on the various treatment modalities. At present, treatment modalities for keloid include: intralesional steroid injection, silicon gel dressing, pressure garment, surgical excision, cryotherapy, irradiation and laser therapy.

When faced with these options, how does one choose the most suitable therapy for the patient? In this issue, Sinead et al provide us with an overview of the clinical data that are currently available. This will give us a clearer picture of the current evidence for the various treatments for keloids.

Obviously treatment should be tailored to the preference of the patient and clinical characteristics of the lesion. For example, intralesional steroids are painful and repeated injections are necessary for effect and may not be suitable for extensive lesions. On the other hand, silicon dressings have to be worn for prolonged periods to be effective and may be less desirable in countries with a hot humid climate. Apart from excision followed by adjunctive therapy such as radiotherapy or steroid injections, all other forms of treatment will take time to have an effect. As there is also a high recurrence rate, long term monitoring is required. All this must be explained to the patient at the start of therapy.

Faced with these issues, prevention is the best means. Ideally, one should avoid keloid formation by all means possible. Therefore avoidance of unnecessary surgery is important. If surgery is unavoidable, a proper explanation of possible keloid formation in those with a past history or family history of keloids prior to surgery or laser is essential. The risk of keloid formation can be reduced

by minimising wound tension, ensuring that incisions follow Blaschko's lines, avoiding incisions that cross the joint space and the sites at higher risk of keloid formation as mentioned above. As acne can also lead to keloid formation, prompt treatment of this condition is needed in predisposed individuals. Despite the various treatment modalities available, keloids remain difficult to manage. More formal trials and data on the treatment of keloids are therefore required.

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References

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