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Letter

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Study conducted at Universidade Estadual de Ponta Grossa (UEPG) – Ponta Grossa (PR), Brazil.

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Comments: Hemiface comparative study of two phenol peels (Baker-Gordon and Hetter formulas) for the correction of facial rhytids

Comentários: Estudo comparativo de hemifaces entre dois peelings de fenol (fórmulas de Baker-Gordon e de Hetter), para a correção de rítides faciais

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Dear Editors,

We read the Vasconcelos et al 1 article with great interest. In our experience, the most worrisome hypochromia or achromia caused by phenol-croton peels occur after resolution of the erythema and post-inflammatory hyperpigmentation, usually longer than 6 months. Did the patients' and doctors' opinion change after extended follow up? The article needs a few corrections:

1 The Hetter's formula chosen was the "medium-heavy" of the 1996 Heresy Phenol Formulas.²

2 Croton oil concentrations were: (Table 1), Baker-Gordon: 2.1%. Hetter: 0.7%.²

3 Was the dose of analgesic used 1 100mg vial of 50 mg/ ml tramadol? At home: what was the dose of tramadol used? The standard presentations usually contain 50 or 100 mg. Or was codeine prescribed, which standard dose is 30 mg?

We would also like to suggest that for future split-face studies, which are the gold standard to evaluate cosmetic facial treatments, the side for each individual be randomized, as we usually see that the left side is more prone to photoaging in countries where the driver seat is on the left side.³

Hetter's formulas have varying storage concentrations (croton oil 4% in phenol 84%) – which would be the most concentrated formula ever reported and that has only been used during Cross in icepick scars, earlobe incomplete tear repair and actinic cheilitis treatment,⁴ –and the very light formula (croton oil 0.105% in phenol 27.5%) – which is the most diluted formula and safest to use on the eyelids.^{2,4}

Dr. Hetter's comments

First of all, I would like to tell the authors that I was very happy to see a chemical peel clinical research article using the split-face approach to compare results of different component concentrations and formulas.¹ I have been encouraging this approach for a long time, but I have not seen many colleagues performing and following patients adequately as to lead to a publication. So, congratulations to the authors for the courage of employing this valuable technique.

What is disappointing about his article are some affirmations that were not based in facts.

1)I was identified as a Canadian plastic surgeon. That is incorrect.

2)They affirm that Dr. Baker started studying his formula in 1950. This is not true. Dr. Baker started studying his formula in 1960, together with Dr. Litton and Dr. Georgiade, as described in my article published in 2000, based on phone interviews with the three of them.

3)My study dates are described incorrectly in the Brazilian article, but are clearly informed in my articles.

Where did the authors gather these non-documented disinformations? The authors must publish correctly the all the wrong dates and facts as to ensure that scientific articles do not become a tabloid journalism or "fake news", so popular in this day and age. Sticking to documented facts is crucial in the scientific community.

The authors did not mention the pig study⁵ conducted at Wisconsin University in 2002 and published in 2009 by Dr. Larson as main author, that verified the conclusions of my articles published in $2000.^2$

The authors apparently concluded that the phenol concentration is of primary importance. The clinical studies in my 2000 article2 and the study in pigs published in 2009⁵ show many evidences that the croton oil concentration is more important. Phenol is required as a vehicle in which croton oil is dissolved. The amount of application layers or passes is also important and validated by the study performed in pigs. The presence of septisol also enhances the clinical effect, but croton oil has the primary action.

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PARTICIPATION IN THE ARTICLE:

Carlos Gustavo Wambier: Writing of the manuscript Critical review

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