

A LARGE 12-MONTH EXTENSION STUDY OF AN 8-WEEK TRIAL TO EVALUATE THE SAFETY AND EFFICACY OF TRIPLE COMBINATION (TC) CREAM IN MELASMA PATIENTS PREVIOUSLY TREATED WITH TC CREAM OR ONE OF ITS DYADS

Helen Torok MD,^a Susan Taylor MD,^b Leslie Baumann MD,^c Terry Jones MD,^d Joshua Wieder MD,^e Nicholas Lowe MD,^f Michael Jarret MD,^g Pheobe Rich MD,^h David Pariser MD,ⁱ Eduardo Tschen MD,^j Dale Martin MD,^k Alan Menter MD,^l Jonathan Weiss^m

a. Trillium Creek Dermatology, Inc, Medina, OH

b. Dermatology Associates, St. Luke's-Roosevelt Hospital, New York, NY

c. University of Miami, Miami, FL

d. J&S Studies, Bryan, TX

e. Private Practice, Los Angeles, CA

f. Clinical Research Specialists, St. John's Hospital, Santa Monica, CA

g. DermResearch, Inc, Austin, TX

h. Dermatology Specialists Northwest, Portland, OR

i. Eastern Virginia Medical School and Virginia Clinical Research, Inc, Norfolk, VA

j. Academic Dermatology Associates, Albuquerque, NM

k. Skin Surgery Medical Group, Inc, San Diego, CA

l. Texas Dermatology Associates, Dallas, TX

m. Gwinnett Clinical Research Center, Snellville, GA

Abstract

This was a 12-month extension of a randomized, investigator-blinded, multicenter, 8-week trial with triple combination (TC) cream in facial melasma. A total of 585 patients were enrolled in the study and 569 patients received study medication. Three hundred eighty-nine patients completed 6 months of treatment and 327 patients completed 12 months of treatment. TC cream demonstrated a favorable safety profile; only 14 patients (2.5%)

did not lead to withdrawal. From the 12-month follow-up, 11 patients (3.4%) were withdrawn from the study.

At 12 months, 80% of patients had regions completely cleared or nearly cleared. Once daily application of TC cream applied intermittently over a long period is a safe, tolerable, and

effective treatment for moderate to severe melasma of the face.

Introduction

Cutaneous melasma is a common dermatological disease occurring in all skin types, but more commonly in darker skinned persons such as Asian and Hispanic females of child-bearing age.^{1,5} Exposure to solar UV radiation is the most important environmental factor in the pathogenesis of melasma.^{2,3} Therapy for melasma remains a challenge and pharmacological treatments are the mainstay.^{2,6,7} Hydroquinone (HQ) has been the gold standard depigmenting agent, and has been used alone or in combination. Other treatments, such as azelaic acid, tretinoin, alpha and beta hydroxy acids, and topical corticosteroids

have been used as monotherapy or in various combinations.^{7,11-15}

Kligman and Willis found that monotherapy with HQ, tretinoin (RA), or the topical corticosteroid dexamethasone did not produce substantial lightening of the skin within a 3-month treatment period. However, they did observe satisfactory results with a combination of 0.1% RA, 5.0% HQ, and 0.1% dexamethasone in a hydrophilic ointment.¹⁵ Furthermore, Kligman and Willis, as well as other researchers have noted efficacy and safety benefits with use of HQ, RA, and various topical steroids. In both

experimental and clinical studies, the use of RA and other retinoids has been found to abrogate the epidermal atrophy that can occur with topical corticosteroids. This may be potentially due to the ability of RA and other retinoids to induce hyperplasia of epidermal cells as well as dermal collagen synthesis.^{16,17}

A stable fixed combination cream has been developed containing fluocinolone acetonide (FA) 0.01%, a low potency (Group VI) corticosteroid, hydroquinone 4%, and tretinoin 0.05% and is currently marketed under the trade name of Tri-Luma® Cream (Galderma Laboratories L.P., Fort Worth, TX) and hereafter called TC (triple combination). This combination was tested in two 8-week, multicenter, randomized, investigator-blind studies in a total of 641 patients with moderate to severe melasma.¹⁸

TC cream was shown to be significantly more effective in achieving total clearing of melasma than any of its dyads (defined as a combination of 2 of its active ingredients). In addition, TC cream demonstrated favorable safety and tolerability following 8 weeks of once daily application in the evening. As melasma is a long-term, recurring disease, it was important to test this triple-combination in patients treated intermittently for a longer duration. Hence we extended our 8-week study to confirm the local and

approximately 30 minutes before bedtime after washing the facial area with a mild cleanser. A thin layer was applied to cover the whole melasma lesion including the outside of its borders extending to the normal pigmented skin. A sunscreen with a sun protection factor 30 and both ultraviolet A and B protection was provided for daily use. Protective clothing and avoidance of sun exposure to the face was recommended and cosmetics were allowed.

Patients who entered the present study fell into 2 groups. The first group included those patients with a satisfactory resolution of melasma (melasma severity score 0: melasma lesions approximately equivalent to surrounding normal skin or with minimal residual hyperpigmentation or 1: mild, slightly darker than surrounding normal skin) after 8 weeks of treatment. These patients were followed every 2 months and re-treated as necessary once daily. The second group included those patients who did not achieve satisfactory melasma severity scores during the initial 8-week randomized study (melasma severity score > 1). This category of patients was re-treated once daily upon entry and followed-up monthly during re-treatment until satisfactory resolution or lack of response was demonstrated, at which time treatment was stopped except for use of sunscreen. They, like the previous group of patients, continued to be followed-up every 2 months when

amendments, and in compliance with local regulatory requirements. Patients provided written informed consent prior to study procedures. All study sites received written International Review Board (IRB) approval before initiation of the study.

Patients were at least 18 years of age, of either gender, with melasma of the face and previously enrolled in a 8-week randomized clinical trial with TC cream or one of its dyads.¹⁸ In the present extension study, all patients were treated with TC cream, irrespective of their previous

skin or black dots were specifically solicited by the evaluator at each visit. Laboratory testing consisted of complete blood count, serum chemistries, and urinalysis.

To assess efficacy, the severity of the patient's melasma was scored at each visit by the investigator as follows: 0 melasma lesions approximately equivalent to surrounding normal skin or with minimal residual hyperpigmentation; 1 mild (slightly darker than the surrounding normal skin); 2 moderate (moderately darker than the surrounding normal skin); 3 severe (markedly darker than the surrounding normal skin). The physi-

visit as follows: 0 completely clear, no evidence of hyperpigmentation; 1 nearly clear, only minor visual evidence of hyperpigmentation; 2 significant evidence of hyperpigmentation.

A patient's global assessment of melasma, which included an assessment of all treated areas, was performed at each treatment visit as follows: 1 completely cleared; 2 nearly cleared; 3 significant hyperpigmentation present.

Statistical Methods

All patients who received the study drug were included in the analyses (intent-to-treat [ITT] Population).

Descriptive statistics were provided for all variables for all patients in the ITT Population. For certain variables, descriptive statistics were provided broken down by treatment group in the initial 8-week study and by duration of treatment with TC cream.

Results

A total of 585 patients were enrolled in the study and 569 patients received study medication. A total of 389 patients completed the first 6 months of the study and 327 patients completed the 12 months treatment. The most common reasons for discontinuation were patient request (31%) and lost to follow-up (25%). The ITT population consisted of 569

patients: 142 (25%) from the TC cream group and 427 (75%) from the dyad groups in the initial 8-week randomized study. Details on Baseline characteristics are provided in Table 1.

The mean cumulative exposure to TC cream in the present study was 204 days. When data were combined with data from the initial 8-week study, the mean cumulative exposure to TC cream was 218 days (256 days in the previous TC study). A total of 330 patients applied the cream for more than 180 days and 92 patients applied TC cream for more than 360 days. There was an average of 2 treatment courses. Each one required less time to achieve the desired result. Patients were re-treated as often as needed.

A total of 346 patients (61%) experienced treatment-related AEs (Table 3). The most commonly reported AEs were application site erythema and application site desquamation, both occurring in approximately one third of patients. Most of these treatment-related AEs were mild, transient, did not require remedial therapy, and did not result in discontinuation from the study.

Application site AEs tended to have an increase in incidence with longer treatment duration. However, the incidence of treatment-related AEs in patients who had 2 treatment courses (66%) was not notably higher than the incidence in those patients who only had one treatment course (60%). These AEs also tended to have a higher incidence in patients over 40 years of age, in non-Caucasian patients, and in patients with skin phototypes I to III. Skin atrophy/thinning occurred in 2 patients and rosacea occurred in one patient (both less than 1%), facial telangiectasia occurred in 23 patients (4%). The 2 cases of skin atrophy/thinning described were mild and did not result in study discontinuation; one case had resolved by the end of the study and one case was unchanged. All 23 cases of telangiectasia were mild and only 2 resulted in study discontinuation; 15 cases had resolved or improved by the end of the study while 8 cases were unchanged.

Overall, TC cream was well tolerated by patients and only 14 patients (2.5%) had treatment-related AEs leading to discontinuation of the treatment. TC cream was not associated with any serious adverse events or clinically meaningful laboratory changes.

Table 1. Patient Demographics.

	Number (%) of patients 569 (100.0%)
Age in years Mean±SD	43.2±8.9
Gender Male	9 (2%)
Female	560 (98%)
Race Caucasian	375 (66%)
Black	16 (3%)
Asian	24 (4%)
Other	154 (27%)
Skin Phototype I	52 (9%)
II	178 (31%)
III	221 (39%)
IV	118 (21%)

Table 2. Treatment-Related Adverse Events Occurring in 5% or More of Patients.*

	All patients	≥ 180 days	≥ 360 days in
Application site burning	43 (8%)	29 (9%)	32 (8%)
Application site desquamation	101 (27%)	103 (33%)	120 (31%)
Application site dryness	52 (9%)	33 (10%)	38 (10%)
Application site erythema	187 (33%)	126 (38%)	142 (36%)
Application site hyperpigmentation	30 (5%)	21 (6%)	24 (6%)
Application site pruritus	27 (5%)	22 (7%)	23 (6%)
Application site rash	35 (6%)	20 (6%)	27 (7%)
Application site reaction	37 (7%)	24 (7%)	29 (7%)

*Treatment-related AE = an AE considered by the investigator to be possibly or probably related to study drug.

† Patients with ≥ 180 cumulative days of treatment with TC cream (includes the initial 8-week randomized study).

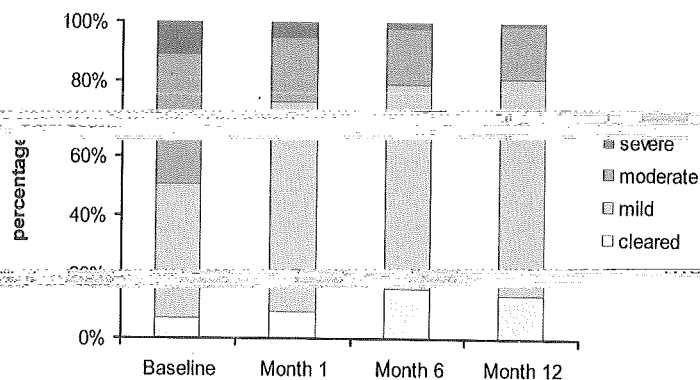
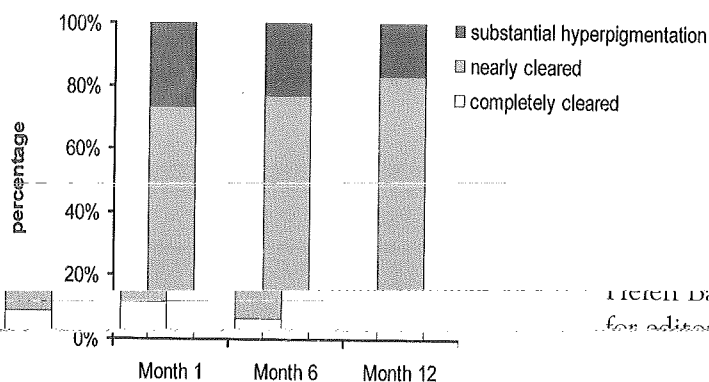
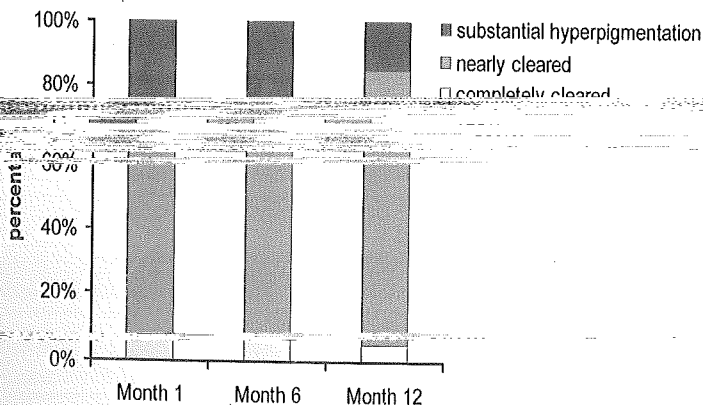
While evaluation of efficacy was not the primary purpose of the study, selected efficacy parameters were collected and examined. The physician's assessment of melasma severity showed that at Month 12 substantially more patients had mild or cleared lesions compared with Baseline (Figure 1). This was particularly evident in those patients who received dyads in the initial 8-week study.

At Baseline, 59% of patients in the previous dyads groups had mild or cleared lesions. For patients in the previous dyads groups, the incidence of

The Patient's Static Global Assessment paralleled the findings of the other efficacy variables (Figure 3). Again, the effect was particularly remarkable for the prior dyads group.

Discussion and Conclusion

The present 12-month extension study, which is the only long-term safety evaluation of TC cream conducted in patients with melasma, demonstrated that TC cream applied intermittently or continuously over one year demonstrated a favorable safety profile in the treatment of

Figure 1. Physician's Assessment of Melasma Severity Over Time.**Figure 2.** Physician's Static Global Assessment of Melasma.**Figure 3.** Patient's Static Global Assessment of Melasma.

TC cream as both hydroquinone and tretinoin are known to cause a certain amount of irritation of the application site.^{1,2}

In the past, concerns have been expressed regarding the risk of skin atrophy and telangiectasia following long-term topical administration of corticosteroids.⁷ However, only 2 cases of skin atrophy/skin thinning in the present study

were reported and both were mild and did not result in study discontinuation. This low incidence may be due to the presence of the tretinoin, which has been demonstrated to prevent corticosteroid-induced atrophy without lessening the anti-inflammatory effect.^{16,17} Only 4% of the patients

developed mild telangiectasia from which 2 resulted in study discontinuation. The relatively low incidence of these side effects after such a long treatment period and the fact that they are commonly associated with corticosteroids

due to the fact that fluocinolone acetonide in a concentration of 0.01% is a relatively low potency (Class VI) corticosteroid. Both physicians and patients reported clinically significant improvements in melasma lesions during the 12-month extension of treatment.

In conclusion, the present 12-month extension study confirmed recent research work demonstrating that TC cream applied once daily over a long-term period is a safe, tolerable, and effective treatment for melasma of the face.¹⁹

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References

1. Grimaldi DE, Micali S. Melasma. In: Fitzpatrick TB, ed. *Medical and Surgical Dermatology*. Philadelphia, Pa: JB Lippincott; 1999:1017-1019.
2. Mosher DB, Fitzpatrick TB, Ortonne J-P, Hori Y. Hypomelanoses and hypermelanoses. In: Freedberg IM, Eisen AZ, Wolff K, et al, eds. *Fitzpatrick's Dermatology in General Medicine*. Vol. 1. New York, NY: McGraw-Hill; 1999:945-1017.
3. Barankin B, Silver SG, Carruthers A. The skin in pregnancy. *J Cut Med Surg*. 2002;6(3):236-240.
4. Sober AE, Fitzpatrick TB. Disturbances of pigmentation. Section I. Mechanisms of pigmentation in man. In: Moschella SL, Pillsbury DM, Hurley HJ, Jr, eds. *Dermatology*. Vol 2. Philadelphia, Pa: WB Saunders Co; 1975:1085.
5. Vasquez M, Maldonado H, Benmaman C, Sanchez JL. Melasma in men. *Int J Dermatol*. 1988;27(1):25-27.

6. Pathak MA, Fitzpatrick TB, Kraus EW. Usefulness of retinoic acid in the treatment of melasma. *J Am Acad Dermatol.* 1986;15:894-899.
7. Giannotti B, Melli MC. Current approaches to the treatment of melasma. *Clin Drug Invest.* 1995;10(suppl 2):57-64.
8. Griffiths CEM, Finkel LJ, Ditre CM, Hamilton TA, Ellis CN, Voorhees JJ. Topical tretinoin (retinoic acid) improves melasma. A vehicle-controlled, clinical trial. *Br J Dermatol.* 1993;129:415-421.
9. Verallo-Rowell VM, Verallo V, Graupe K, Lopez-Villafuerte L, Garcia-Lopez M. Double-blind comparison of azelaic acid and hydroquinone in the treatment of melasma. *Acta Derm Venereol.* 1989;143(suppl):58-61.
10. Sanchez JL, Vazquez M. A hydroquinone solution in the treatment of Melasma. *Int J Dermatol.* 1982;20:55-58.
11. Kimbrough-Green CK, Griffiths CEM, Finkel LJ, Hamilton TA, et al. Topical retinoic acid (tretinoin) for melasma in black patients. *Arch Dermatol.* 1994;130:727-733.
12. Gano SE, Garcia RL. Topical tretinoin, hydroquinone, and betamethasone valerate in the therapy of melasma. *Cutis.* 1979;23:239-241.
13. Kligman AM, Willis I. A new formula for depigmenting human skin. *Arch Dermatol.* 1975;111:40-48.
14. Katsambas A, Antoniou Ch. Melasma: classification and treatment. *J Eur Acad Dermatol Venereol.* 1995;4:217-223.
15. Kligman LH, Schwartz E, Lesnik RH, Mezick JA. Topical tretinoin prevents corticosteroid-induced atrophy without lessening the anti-inflammatory effect. *Curr Probl Dermatol.* 1993;21:79-88.
16. McMichael AI, Griffiths CE, Talwar HS, Finkel LJ, et al. Concurrent application of tretinoin (retinoic acid) partially protects against corticosteroid-induced epidermal atrophy. *Br J Dermatol.* 1996;135(1):60-64.
17. Taylor S, Torok H, Jones T, et al. Efficacy and safety of a new triple combination agent for the treatment of facial melasma. *Cutis.* 2003;72:67-72.
18. Torok HM, Jones T, Rich P, Smith S, Tschen E. Hydroquinone 4%, tretinoin 0.05%, fluocinolone acetonide 0.01%: a safe and efficacious 12-month treatment for melasma. *Cutis.* 2005;75(1):57-62.

Address for Correspondence

Helen Mary Torok MD
Trillium Creek Dermatology Center
5783 Wooster Pike Road
Mason, OH 45040