Chapter 8
Treatment of Truncal Acne Scarring

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Introduction

Acne vulgaris is a common condition with a lifetime incidence of over 80%. Acne scarring is an unfortunate, yet, frequent sequela of acne. Any type of acneiform lesion, including comedones, papules, pustules, or nodulocystic lesions, may result in scarring. Although it is impossible to pinpoint exactly which patients with acne will develop scarring, there are some factors that put a patient at higher risk. Acneiform lesions that have been manipulated are more likely to result in scarring. Truncal acne scarring is more common in males than females, and Asian and Black patients are especially prone to keloidal scarring. More severe acne and especially acne conglobata, (Fig. 8.1) has a higher risk of leading to scarring.

Several factors may predispose a patient to acne scarring. Prolonged angiogenesis is seen in lesions that proceed to scarring compared to lesions that resolve without scarring. An excess of metalloproteinases, such as collagenases, may also play a role in scar formation. One study showed that nonscarring patients developed peak inflammation 48 h after an acneiform lesion had arisen. Patients with acne scars developed an inflammatory response later in the acne lesion’s evolution and the inflammation was slower to resolve (Fig. 8.2).

Patient History and Clinical Examination

Evaluation of a patient with truncal acne scarring requires consideration of several issues. The age of the scars should be determined since scars continue to evolve over 12 months and some treatment modalities (such as the pulsed dye laser) work best for newer scars. The distribution of the scars should be noted as certain treatments are best utilized for scattered individual scars, while other treatments may be needed for widespread scars. It is also important to identify the acne scar morphology, as different treatment modalities are preferable for particular types of scars. Previous use of isotretinoin should be known, since recent use of isotretinoin (within the last year) may preclude some procedures due to the potential increased risk of scarring.

Facial acne scars have been classified into three primary morphologic types: icepick, boxcar, and rolling scars. While these scar morphologies can also be seen on the trunk, acne scars on the chest and back are usually either: (1) hypertrophic/keloidal (Figs. 8.3–8.5), or (2) atrophic (Figs. 8.6 and 8.7). Some therapies may be directed to both types of scarring, while other therapies are specific to either hypertrophic/keloidal scars or atrophic scars.

Therapeutic Considerations and Applications

The best treatment for scars on the trunk is prevention. Patients who delay starting antiacne medications for at least 3 years from acne onset, have a greater degree of scarring than those who start acne treatment earlier. Isotretinoin therapy is the only proven cure of acne and should be instituted early in the course of severe acne in order to prevent scarring.

Excision

If scarring does occur, either type of acne scars on the trunk may be treated by surgical excision. Given the high tension of the truncal skin, patients should be warned of the high likelihood that the surgical scar