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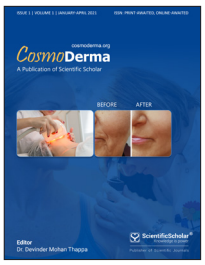

Letter to the Editor

Comments on "The clinical approach to botulinum toxin in dermatology: A literature review"

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Quick Response Code:

Dear Sir,

I have read, with great enthusiasm, the article entitled "The clinical approach to botulinum toxin in dermatology: A literature review," authored by Abbas *et al.*[1] published in the March 2023 edition of CosmoDerma. The article is very interesting and discusses the application of botulinum toxin in dermatology. I congratulate the authors for the article presented. However, I would highlight some important points.

Botulinum toxin is a drug of biological origin that causes a dose-dependent transient paralysis of muscles, clinically observed in dermatology for the attenuation of expression lines and wrinkles. In the introduction of the article,[1] the colleagues presented the function of filling. This statement is untrue, since the toxin is presented as a lyophilized powder that should be reconstituted in saline solution, presenting itself for use as a liquid.[2] The application of this liquid compound cannot provide the filling effect.

It was reported the possibility of occurrence of botulism caused by the injection of large amounts of botulinum toxin. In dermatology or dentistry, this possibility is almost null, precisely because of the amount to be applied. This statement in the scientific article can be dangerous by disseminating untrue information.[2]

Commercially, there are bottles of 50, 100, and 200 units (Botox™ or Vistabel™, Allergan Pharmaceuticals, Westport, Ireland) or of 300 and 500 units of botulinum toxin type A (Dysport™ or Azzalure™, Ipsen Biopharm Ltd., Wrexham, UK). The reconstitution should follow the guidelines recommended by the manufacturers of each brand. Botulinum toxin Type B (Myobloc™, Supernus Pharmaceuticals, Inc., Rockyville, MD, US, and Neurobloc™, Solstice Neurosciences Inc., San Francisco, CA, US, respectively) is available in the North American and European markets. Its dosage is higher, with bottles of 3000 to 5000 units. In the past, in view of excessive applications of botulinum toxin Type A, the toxin became more susceptible to sensitization reactions, making it necessary to develop new products. Botulinum toxin Type B is stronger, but more immunogenic, compared to botulinum toxin Type A. However, its use should be considered, in view of the possible risks of immunogenicity.[2]

In the article,[1] it was proposed a dosage scheme for certain anatomical regions among patients of both genders. However, it should be emphasized that the applications should be particularized in each case. The application protocol should not be fixed.[2] In the same perspective, considering 500 units of botulinum toxin is an unimaginable exaggeration in specialties such as dermatology or dentistry.

Considering that the article deals with applications in dermatology, and the gastrocnemius muscle is excluded from this hall for esthetic applications, I recommend the exclusion of this target muscle and indicated posology, to avoid quantitative implications and their respective application sites, particularly in the area of dermatology.

It was proposed that the gummy smile can be treated with botulinum toxin applications in the muscles whose action is medial. It is worth mentioning that the gummy smile can be classified as anterior, posterior, and mixed, varying according to the greater activity of the upper lip lift muscles, and not only in the medial region of the upper lip.[2-5]

As mentioned in the article,[1] botulinum toxin is indicated for sialorrhea or hypersalivation. However, within the scope of stomatology, this application should be very carefully considered in view of the possible risks and damages of xerostomia in the oral cavity, and should only be considered in patients with special needs. These applications are better indicated in the larger salivary glands of the oral floor, whose saliva produced has a mucous characteristic. The saliva produced by the parotid glands is serous (more fluid) in its constitution, and stimulated by feeding, not fitting the indication of application in the parotid glands.[2]

The therapeutic modalities proposed to blepharoptosis present, as reported in the article,[1] partial results in a period of time consistent with the duration of the botulinum toxin. This possible complication can and should be avoided by the establishment of a refined technique by the prescribing professional.[2]

In the conclusions of the article,[1] the authors report "Botox A" and "Botox B." Botox™ is one of the trademarks of botulinum toxin Type A. The nomenclature employed should be avoided and is incorrect, since there is no trademark Botox™ as botulinum toxin Type B.

Declaration of patient consent

Patient's consent not required as there are no patients in this study.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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