LETTER TO THE EDITOR

I would like to commend Schweiger et al for their article "Comparison of Poly-L-lactic Acid and Calcium Hydroxylapatite for Treating Human Immunodeficiency Virus–Associated Facial Lipoatrophy" (*Cosmet Dermatol*. 2007;20:304-312). Their comparison of these 2 products in the management of human immunodeficiency virus (HIV)–associated facial lipoatrophy was informative and well constructed. However, I wish to comment on and clarify a few points that were reported in the article regarding the duration of the 2 therapies and the incidence of nodule formation.

The durability of calcium hydroxylapatite (CaHA) is reported as 12 to 18 months in Table 3,[1] but there are no primary references cited. This statement may be derived from unpublished data described in the text as based on subjective patient reporting of improvements at an 18-month follow-up rather than clinical measures. My personal experience is consistent with the CaHA package insert,[2] which states that the benefits last for up to 1 year. Based on my clinical experience and my published study on the treatment of HIV-associated facial lipoatrophy, I agree with the authors that the effects of poly-L-lactic acid (PLLA) are sustained for up to 2 years.[3]

The article also notes that both agents are associated with the potential formation of nodules. However, when discussing the results of HIV-negative patients published by Jansen and Graivier,[4] the initial statement that "nodule formation was not reported" is then qualified to acknowledge the incidence of nodule formations when CaHA is injected into the lip or the area surrounding the lip. The increased risk of nodule formation has led many clinicians to avoid injecting this agent in the perioral region. I have not experienced nodule formation with CaHA when used outside the perioral region. However, I have found that the incidence of nodule formation associated with PLLA injections may be reduced through the use of higher dilution volumes (eg, 5 mL sterile water versus 3 mL; a range of 3–5 mL is noted in the package insert) in conjunction with appropriate post-treatment care (eg, massaging of the treatment area). At dilutions of 5 mL, I have not experienced any nodule formation with PLLA in my patients. This association between dilution volume and nodule formation is suggested by the data summarized in Table 1 of Schweiger et al.[1] A prospective study comparing incidence of nodules with various reconstitution volumes for PLLA, as well as other injectable agents, would be a valuable guide for clinical practice.

Both CaHA and PLLA are approved by the US Food and Drug Administration and are well tolerated and effective injectable treatment options for the management of HIV-associated facial lipoatrophy. It is important that clinicians have access to accurate information when choosing the most appropriate treatment for their patients.

Sincerely,
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REFERENCES

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