KP is caused by a disorder of keratinisation of the lining of the upper part of the hair follicle. Small plugs of keratin from dead skin cells block the hair follicles, instead of the scales exfoliating, causing an unsightly, rough, spotty appearance. In-growing hairs may occur in the plugs. In more than half of the cases it is genetic (autosomal dominant inheritance), but otherwise the causes are not fully understood

The rough with the smooth

Dr Sarah Norman on how to manage keratosis pilaris in your aesthetic practice

Keratosis Pilaris ("KP"), or chicken skin arms as it is commonly known, is a troublesome condition of all ethnicities, occurring in one in three adults, and over half of all adolescents. Affected skin is rough and has the appearance of permanent goose bumps.

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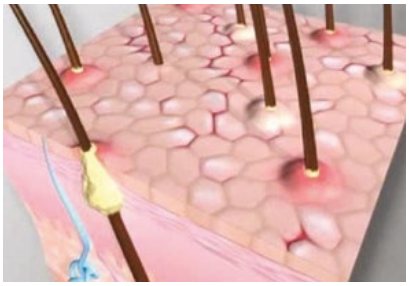
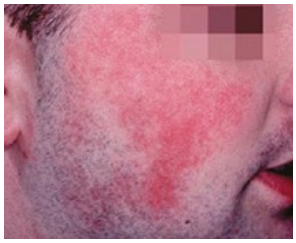
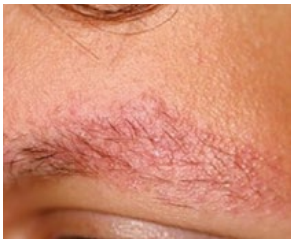


Diagrammatic representation of keratosis pilaris with blocked hair follicles

KP is common on the upper outer arms and thighs but can also affect the face, buttocks, hands or, in fact, any part of the body where there are hair follicles. The distribution is always symmetrical. Occasionally the skin can be itchy, but the condition itself is quite harmless. It tends to be worse in the winter months.

There are a number of common types of KP including KP rubra (red bumps), KP alba (bumps which are not inflamed), hyper-pigmented KP (brown spots) and KP rubra faceii (known as KPRF, a reddish rash on the cheeks, like rosacea). An uncommon type is KP atrophicans where loss of hair and small scar-like depressions can occur. Eyebrow KP (known as Ulerythema Ophryogenes) is one manifestation of this.


KP Rubra Faceii (KPRF)


Ulerythema Ophryogenes (Eyebrow KP)


Keratosis Pilaris

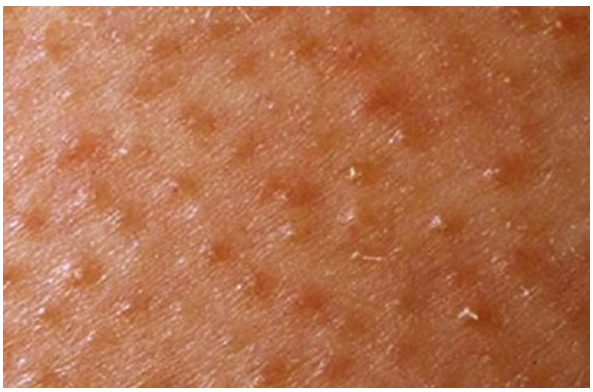
Treatment for KP on body skin is not absolutely necessary, but is often sought for cosmetic reasons. To begin with I advise avoiding using solid soap (which may irritate the skin and exacerbate dryness) and also avoid heavy moisturising creams (which can reduce the skin's natural exfoliating cycle). Encouraging exfoliation (for example, with plastic exfoliating gloves for the body, or a granular exfoliator) will improve affected body skin.

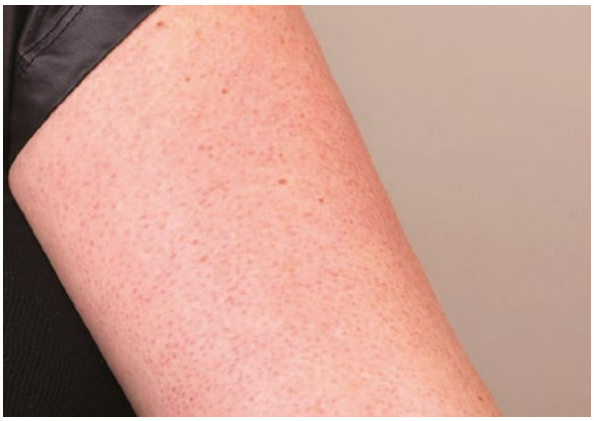
If symptoms persist, topical creams containing chemical exfoliators (to help to slough off the skin) can be very effective. In addition, topical retinoids have a number of beneficial effects: restore natural hydration, increase cell turnover, repair damaged keratinocytes (epidermal cells) and they also stimulate collagen/ elastin.

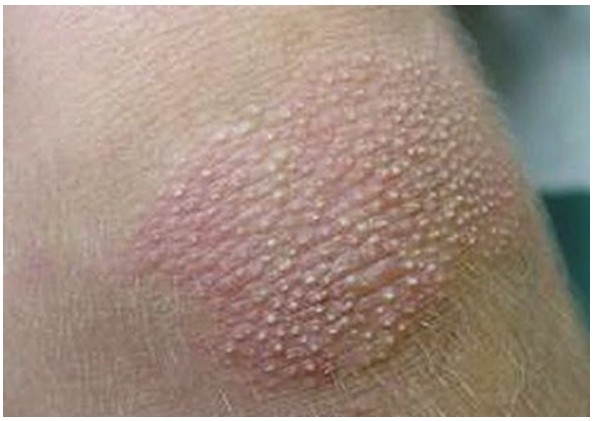
My personal choice is the Oraser Body Emulsion Plus by ZO® Skin Health, which contains retinol, urea, exfoliating plant enzymes, the anti-oxidants Vitamins A, C and E, and DNA repair agents. It also treats the pigmentation, inflammation and dryness which often accompanies KP. In my clinical practice I have found it successful in providing relief for my patients.

Specific subtypes of KP can require further attention. For example, Ulerythema Ophryogenes (where the eyebrows are affected) is exacerbated by UV radiation and, given that loss of hair can occur, sun protection is particularly important. In KPRF (rosacea-type rash on cheeks), sun protection is similarly paramount. In my practice I find thermo-coagulation to be a very effective procedure in reducing the redness associated with KPRF.

Aesthetic practitioners are likely to frequently encounter this troublesome skin disorder in their clinical practice. Although it is a life-long condition, providing sound advice on management will undoubtedly be rewarding for both patient and practitioner. **AM**


KP on the knee


KP on the upper arm


Pigmented KP

Dr Sarah Norman BM BS BMedSci (Hons) DRCOG MRCGP MEWI MBCAM, has been in private practice for over eighteen years, and is now Clinical Director at BrightNewMe, a facial aesthetics and skincare clinic in Altrincham, Cheshire. She has a special interest in aesthetic dermatology, having a strong belief in improving the underlying quality of patients' skin before they consider non-surgical treatments. She is Chair of the Trafford Division of British Medical Association.