the anthralin formulation. Salicylic acid peel is an office-based procedure done under controlled conditions; whereas anthralin is a self-treatment opted by patients which is totally unsupervised and frequently leads to irritant reaction. About 30% salicylic acid peel is commonly used for sensitive facial skin for acne and commonly does not lead to severe irritant reaction. Any sweeping statement claiming that "we should not expect clearance with superficial peel like salicylic acid 30%," if the proprietary anthralin formulation has failed to do that, is based on assumption rather on fact. Salicylic acid peel resulted in fungal clearance in most of our patients as presented in our paper. About 88% of our patients achieved mycological cure one week after the last application without use of oral antifungal agents. We have documented good improvement with topical therapy (salicylic acid peel) in our study for a pandemic-like condition of superficial fungal in India. There is no documented study comparing the efficacy of salicylic acid peel and anthralin in dermatophytosis. In our single-arm study, we have not studied the role of anthralin in tinea keeping in mind the severe irritant reaction.

The advantage of using salicylic acid peel in dermatophytosis lies in the fact that it does not affect the fungal organism directly; hence, it will not lead to fungal resistance even after incorrect use as seen with most of the antifungals.

Use of antifungal drugs in treatment-naïve patient increases the chance of developing drug resistance and that, probably, is the basis of advising more aggressive treatment in the recalcitrant patients. Use of salicylic acid is unlikely to induce resistance and, hence should be strongly promoted in treatment naïve patients, whereas any use of antifungal drugs will increase the risk of developing resistance.

Salicylic acid monotherapy also achieved fungal clearance in clinically terbinafine- and itraconazole-resistant cases with extensive involvement giving additional armamentarium in the treatment of tinea infection in this pandemic. This study was conducted to test the efficacy of salicylic acid peel in dermatophytosis. Hence, it was used as a monotherapy. However, as mentioned in our study, it can be combined with other systemic antifungals. Use of salicylic acid peel should reduce the exposure to antifungal drugs and will prevent further escalation of the antifungal resistance menace and should be used in all cases and not only in recalcitrant ones.

**Declaration of patient consent**

The patient's consent is not required as the patient's identity is not disclosed or compromised.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

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# Letter in response to: 'Efficacy of salicylic acid peel in dermatophytosis'

Sir,

We read with great interest the recently published work entitled 'Efficacy of salicylic acid peel in dermatophytosis' by Saoji *et al*.[1], who have nicely described a new treatment modality in cases of dermatophyte infections which are not responding to routine antifungal drugs.

Although it provides a lot of information in a brief report, we would like to draw attention to few points that, we think, if added, will complete the report.

First, pre-peel precautions, such as covering of sensitive areas like scrotum with petroleum jelly and quick application

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of salicylic acid should be kept in mind while performing the procedure.[2]

Second, when the salicylic acid peel is applied, it crystallises forming a pseudo-frost. It is then washed with water after three to five minutes. The skin is gently dried with gauze and the patient is asked to wash with cold water until the burning subsides. Bland moisturisers should be prescribed post-procedure for dryness and the patient should be asked to avoid peeling or scratching of skin.[2]

Finally, few common local side effects of salicylic acid need to be mentioned and explained, such as prolonged erythema, intense exfoliation, crusting, dryness and pigmentary dyschromias, as salicylic peel is done over extensive areas in this study.[3]

**Declaration of patient consent**

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

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

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# Authors' reply

Sir,

We would like to thank the reader[1] for providing constructive inputs on our paper.[2] The reader has suggested that sensitive areas of skin like scrotum should be protected by a layer of petrolatum. We wholeheartedly concur with the suggestion of the reader and would follow the same in our future practice. However, in our study, we have carefully avoided the areas adjoining the scrotal sac.

Second, the readers have suggested post-peel care in the form of neutralisation of peel with cold water and liberal application of bland emollient/moisturiser. Intense burning in our patients was managed by applying cold compresses and patients were suggested to apply bland emollients over treated areas keeping in mind the disturbed barrier function of epidermis affected by dermatophytosis.

The inputs from the reader would definitely help in increasing the adherence of the patients toward salicylic acid peel in the treatment of dermatophytosis.

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**Conflicts of interest**

There are no conflicts of interest.

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