

was noted to terbinafine in seven, to itraconazole in one, while the rest reported recurrences after initial improvement with antifungal treatment. However, the authors do not specify if any of these patients fulfilled the definition of chronic and recurrent dermatophytosis.⁴ Given this background, the authors could have rather explored the role of salicylic acid in chronic, resistant and recalcitrant dermatophytoses, where all standard therapeutic options would have been exhausted.

Therefore, although keratolytic agents like salicylic acid have been reported to be useful as an adjuvant therapy in dermatophytoses, recommending them as standalone therapeutic agents is questionable.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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Authors' reply

Sir,

We have read the comments made by the authors¹ regarding our paper published in *IJDVL*.² We would like to offer constructive rebuttal to the issues raised by the authors:

Salicylic acid peel as a therapeutic option in the treatment of dermatophytosis was a new idea and we wanted to assess the safety and efficacy for the same. The authors decided to conduct a pilot study to test the safety and efficacy. Usually, pilot studies are conducted on a small sample size of patients (30–50).³

Recurrences in dermatophytosis are a common phenomenon seen with all modalities of therapy and not only with salicylic acid peel. It is well-known that to prevent recurrence, long-term antifungals (systemic or topical or combination) are required. Oral itraconazole therapy is not immune from recurrence once it is stopped; however, it does not mean that itraconazole therapy is not effective against dermatophytes.

Long-term treatment is advised by most experts to prevent recurrence. A treatment which leads to clearance of fungus in a short period will certainly prevent the recurrence if used for long-term. Salicylic acid peel resulted in fungal clearance even when systemic antifungal drugs (resistant cases) failed in clearing the fungus.

Involvement of the vellus hair and its possible role in recurrence of dermatophytosis has been dealt in our paper and needs no further consideration. Salicylic acid, being a lipophilic agent, penetrates hair follicles and may help in exfoliation of infundibular keratinocytes along with fungal elements. We think that comparing salicylic acid peel with a proprietary anthralin formulation is totally unjustified. We have huge cumulative experience of salicylic acid peel with regard to its safety. Salicylic acid peel, being a self-neutralising peel, causes more controlled peeling of epidermis without causing any undesirable irritant reaction in contrast to florid irritant dermatitis after application of

How to cite this article: Saoji VA, Madke B. Authors' reply. *Indian J Dermatol Venereol Leprol* 2022;88:649-50.

Received: September, 2021 **Accepted:** September, 2021 **EPub Ahead of Print:** January, 2022 **Published:** August, 2022

DOI: 10.25259/IJDVL_919_2021 **PMID:** 35146982

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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

How to cite this article: Tandel JJ, Polra RV, Nair PA. Letter in response to: ‘Efficacy of salicylic acid peel in dermatophytosis.’ *Indian J Dermatol Venereol Leprol* 2022;88:650-1.

Received: September, 2021 **Accepted:** September, 2021 **EPub Ahead of Print:** October, 2021 **Published:** August, 2022

DOI: 10.25259/IJDVL_955_2021 **PMID:** 34877853

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