

CONDITIONS · FACE · PIGMENT DISORDERS

Melasma: daily management

Melasma is a chronic, relapsing pigment disorder. Light control, heat control and consistent topical care are the foundation of managing it; in-clinic work is one part of the plan, never the whole of it.

KEY FACTS

What it is	An acquired pigment disorder producing symmetric, soft-edged brown-to-grey patches on sun-exposed facial skin: cheeks, forehead, upper lip, jawline.
What drives it	Overactive melanocytes (not more of them), with vascular changes and low-grade dermal inflammation. Hormones layer on top.
Triggers	UV, visible light and heat. Infrared is an independent trigger, so hot environments and heat-generating devices matter alongside sun.
Who it affects	Predominantly women; Fitzpatrick III to V skin is most susceptible, which describes most people in Singapore.
Course	Chronic and relapsing. Melasma is managed over time rather than removed once.
First step	Diagnosis. Melasma and sun spots look alike and are treated almost oppositely, and they often coexist.

Melasma is not sun spots

Sun spots (solar lentigines) are deposits: they sit where UV has accumulated over years, have defined borders and behave relatively predictably. Melasma is a different condition. It is hormonal, chronic and relapsing, it is heat-sensitive, and it distributes in centrofacial, malar and mandibular patterns rather than as discrete spots. Depth also matters: epidermal, dermal and mixed patterns are established at assessment and change what is appropriate.

“Melasma is managed, not cured. A clinic promising a cure is promising a relapse.”

Dr Sin Yong

Why heat matters as much as UV in Singapore

Singapore sits roughly one degree north of the equator, so UV is high year-round with no seasonal low. The less familiar part is heat and visible light, which are triggers in their own right. A hot yoga class, a steamy walk to the MRT, a kitchen, bright indoor light through windows, or a sunscreen that covers UVB and UVA but not visible light can all contribute, and so can a heat-generating laser applied to the wrong diagnosis.

Your daily routine

Every day

Photoprotection and trigger control are the foundation every other treatment stands on: necessary, seldom sufficient on their own.

- Tinted sunscreen containing iron oxides, applied every morning. Iron oxides block the visible wavelengths implicated in melasma; a clear SPF alone is incomplete protection.
- Reapply when outdoors for long periods or after sweating. Add shade, a hat and sunglasses when you can.
- Indoors counts. Window glass and bright indoor environments still deliver visible light.
- Keep heat down. Saunas, steam rooms, hot yoga and prolonged time near stoves are all triggers worth limiting.
- No scrubbing. Friction is itself a melasma trigger; cleanse gently and avoid abrasive devices and rough towels.
- Use prescribed topicals as directed, in supervised courses. Do not extend a course or borrow products without review.
- Avoid bleaching creams from unregulated sources. Some contain unlisted steroids or high-dose hydroquinone that damage skin with long-term unsupervised use.
- Track honestly. Photograph the area in the same light, at the same angle, at intervals, so change is judged like with like.

How melasma is managed in clinic

The treatment literature ranks combination approaches highest: photoprotection plus evidence-based topicals (triple-combination creams and related regimens lead), with oral and procedural options, including conservative low-fluence laser toning, as adjuncts rather than first weapons. Aggressive single-laser approaches rank poorly because rebound darkening is a documented outcome. The staged sequence Dr Sin Yong follows is: diagnose first, stabilise with topicals and photoprotection, then add gentle energy-based work where indicated, with maintenance planned from day one. Response varies between individuals and is reviewed in person.

Why turning the energy up backfires

With a sun spot, firmer settings often shorten the route. With melasma the same instinct works against you, because thermal injury is itself a trigger. Pushed too hard, melasma commonly rebounds, returning darker than the starting point and harder to manage than before. That risk is higher in Fitzpatrick III to V skin. Settings are therefore chosen for the phototype in front of the doctor rather than for a protocol written elsewhere.

“The laser that clears a sunspot can hand a melasma patient a darker patch than they started with.”

Dr Sin Yong

Who needs extra caution

- Pregnancy and breastfeeding. Melasma often appears or worsens then; elective laser is generally deferred and prescription agents such as hydroquinone, tretinoin and oral tranexamic acid are usually avoided, so gentle photoprotection becomes the main measure.

- Clotting risk. Oral tranexamic acid affects clotting, so a personal or family history of blood clots, a known clotting disorder, smoking and combined hormonal contraception are reviewed before it is considered, and it is not used where the risk is raised.
- Recent tan, active dermatitis, irritation from strong actives, or photosensitising medication: laser or toning is deferred.
- Uncertain diagnosis. A patch that is changing, raised or unlike the rest is examined first and referred for dermatological assessment where needed.

Risks worth knowing

The main risk in melasma treatment is making the pigment worse. Heat-based or aggressive laser can trigger rebound darkening, and frequent repeated low-energy toning of the same area has been linked to pale, mottled spots that can be slow to recover. Creams can cause irritation, redness and peeling and, with prolonged unsupervised hydroquinone use, a bluish-grey darkening called exogenous ochronosis. Oral tranexamic acid can cause stomach upset or lighter periods and, rarely, a blood clot. Risks are reduced by confirming the diagnosis first, screening for clotting risk, using prescription agents in supervised courses, choosing settings for your skin type and reviewing response before anything is escalated.

When to come back for reassessment

- Pigmentation that worsened after a laser or toning session: reassess before booking another rather than continuing the same approach.
- A patch that is changing shape, becoming raised, itchy or unlike the rest.
- New irritation, peeling or redness from a prescribed topical.
- Pregnancy, a new hormonal medication, or a change in general health, since the plan may need to change.

Questions patients ask

Why does my melasma come back every time it clears?

Because the disease is still there: overactive melanocytes, vascular changes and light sensitivity persist under cleared skin. Clearing is a state to be maintained, not a cure that ends care.

Will melasma fade if I just use sunscreen?

Photoprotection stops the fuelling but rarely erases established pigment alone. It is the foundation every other treatment stands on.

Is melasma hormonal?

Hormonal influence is well recognised, which is why melasma commonly appears or worsens in pregnancy and with hormonal contraception. That context is part of the history taken at assessment.

NEXT STEP

Consultations with Dr Sin Yong are by appointment at Orchard Road, Singapore. WhatsApp a short note on your concern to +65 8023 7170 (replies within clinic hours: Mon–Fri 10am–8pm, Sat 11am–3pm). Every assessment is carried out personally; options explained include waiting, no treatment or referral.

SOURCES

- Melasma. StatPearls, NCBI Bookshelf.
- Pathogenesis of melasma explained. PMC.
- Efficacy and safety of different treatments for melasma: network meta-analysis. PMC.
- Tranexamic acid for adults with melasma: a systematic review and meta-analysis. BioMed Research International, 2018.
- Source pages: drsinyong.com/melasma-treatment-singapore/ and drsinyong.com/melasma-condition-guide/