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ANATOMICAL EXHORTATIONS OF BOTULINUM TOXIN INJECTIONS FOR ROSACEA

Dear Editor:

We read Luque and colleague's informative series on the use of botulinum toxin in the treatment of flushing and erythema in rosacea with interest.[1] The authors mark the sites for the intradermal injections in Figure 2 (D). Extreme caution is required when injecting in this area since the depressor anguli oris muscle has a medial border which overlaps with the depressor labii inferioris. We note that the injection points on the chin in their image are on the "no-go zone" on the depressor labii inferioris and injecting into this area might result in drooping of the lower lip, slurring, drooling and dribbling in patients receiving the botulinum toxin. This protrusion of the lower lip has been referred to as a Gomer Pyle appearance.[2] This can lead to the appearance of asymmetry in the perioral region possibly resulting in the need for a further botulinum injection on the contralateral side so that both sides are symmetrical. In addition, if botulinum is injected too laterally, the buccinator muscle might be reached causing the patient to bite down and damage their buccal mucosa.[2] A thorough understanding of the anatomy of the facial muscles is therefore essential when treating the perioral area with botulinum toxin to ensure the safe delivery of this medication.

With regard,

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FIGURE 2. From Luque et al[1]: A, B) Patient with rosacea and persistent erythema on the forehead, cheeks, and chin; C) Dramatic improvement of the facial erythema one month after botulinum toxin application; D) Markings for intradermal injections

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