BEAUTY

Why Melasma Keeps Coming Back

Melasma is built to relapse, but understanding its stubborn pattern can help you avoid chasing increasingly aggressive fixes.

The return can feel personal

The patches had faded. Perhaps not completely, but enough that you stopped checking them in every mirror. Then they deepened again, and the old frustration returned with them. Melasma can make a successful treatment feel as though it has suddenly failed-and make you wonder what you did wrong.

The harder truth is also the more forgiving one: recurrence is part of the disorder. Systematic reviews describe melasma as chronic, relapsing and difficult to treat. No single treatment works universally, and recurrence remains high across treatment groups. A return of pigment is not proof that you were careless or that the improvement was imaginary.

Melasma involves melanin, the pigment that gives skin its colour. Specialised skin cells produce melanin, and changes in that production alter how dark or light the skin appears. Sun exposure can make skin darker, while pregnancy can also increase pigmentation. Melasma predominantly affects women and is particularly common among people with darker skin types.

Its visibility matters, too. Reviews repeatedly note effects on quality of life and self-esteem. That helps explain why recurrence can land so heavily: you are not simply watching colour return. You may be watching the return of something you had already spent time, money and emotional energy trying to leave behind.

Fading is not the same as finished

Much of the confusion begins with the expectation that melasma behaves like a mark that can be removed once. The research describes something different: a chronic, refractory pigmentary disorder. "Refractory" is the clinical word for a problem that resists treatment. "Chronic" and "relapsing" mean that even real improvement may not be permanent.

A 2022 systematic review found high recurrence rates in every treatment group it considered, including topical, systemic and procedure-based approaches. Combination treatments generally produced better results than single therapies, but they did not turn melasma into a

one-off problem. Treatment can reduce visible pigment without removing the tendency for it to return.

That distinction changes how you judge progress. A treatment does not have to deliver permanent clearance to have worked, yet an initial response does not guarantee lasting control. The studies themselves often cannot answer the long-term question well: a 2021 evidence review identified small samples, inconsistent study designs and limited long-term follow-up as major weaknesses in the literature.

The evidence therefore supports modest expectations rather than a miracle narrative. Improvement is possible. Recurrence is common. The space between those two facts is where sensible decisions have to be made, without blaming yourself or allowing every returning patch to trigger a more aggressive intervention.

You are not asking for a promise that melasma will never return.

More treatment is not always more control

The strongest evidence does not necessarily belong to the most elaborate option. A review of 113 controlled studies involving 6,897 participants found that hydroquinone alone and a triple-combination cream containing hydroquinone, tretinoin and a corticosteroid were the most effective and best-studied treatments. Chemical peels and laser- and light-based devices produced mixed results and were equal or inferior to topical treatments overall, with a higher risk of adverse effects.

That does not mean procedures never help. A 2024 systematic review of chemical peels included 24 studies and 1,075 participants, with study periods ranging from 8 to 36 weeks. It concluded that peels were safe and effective, with glycolic acid appearing the safest and most effective among those studied. But the researchers could not combine the results in a meta-analysis because the studies differed too much.

Those findings can coexist. Peels may improve melasma, while the broader evidence still does not establish them as better than the leading topical options. The 2022 review reached a similar conclusion: microneedling and peeling appeared effective, but their superiority to hydroquinone had not been established. Laser and light devices could also be beneficial, yet recurrence stayed high.

More aggressive treatment can introduce another problem. Reported adverse effects include irritation, dryness, burning, redness and post-inflammatory hyperpigmentation (PIH)-darkening that follows inflammation. A separate 2024 review of PIH in people with skin of colour found that laser treatment sometimes worsened pigmentation. Escalation is therefore not

automatically the same thing as progress.

First make sure the name fits

Not every dark facial patch is melasma, and not every area of pigmentation has the same explanation. PIH commonly follows inflammatory conditions and can itself become chronic. Dark circles around the eyes may have pigmentary, structural, vascular or mixed causes. A treatment aimed at pigment will not necessarily address volume loss, loose skin or a vascular contribution.

This is why the 2022 melasma review recommended assessing the pigmentation with a Wood's lamp examination and dermoscopy before selecting treatment for a particular melasma subtype. The point is not that every recurrence requires a new battery of procedures. It is that the label matters before you decide what the returning colour means.

If you have been treating a patch on assumption alone, or if the pattern is not responding as expected, this stops being a shopping question and becomes a medical one. A clinician can assess whether it is melasma, PIH or another pigmentation disorder and discuss which options fit what they see. Questions about your skin should be taken to a healthcare professional rather than settled by appearance alone.

This matters especially before oral treatment or procedures. Oral tranexamic acid has shown promise for moderate or severe recurrent melasma, but reviews say more research is needed on its long-term safety and effectiveness; another review also noted systemic side effects. That is not a treatment to improvise. It belongs in an individual clinical decision.

Ask for a plan that includes relapse

Your most useful next step is not to declare war on the returning pigment. It is to have a treatment conversation that begins with the assumption that recurrence may happen. That conversation takes three clear questions: Is this definitely melasma? What evidence supports the proposed option? What is the plan if the pigment fades and then returns?

Ask what the recommended treatment is expected to buy: initial improvement, longer control, or both. If a peel, laser or light-based procedure is proposed, ask why it is preferable in your case to the better-studied topical options, and ask about irritation and PIH. If an oral medicine is proposed, ask how its uncertain long-term evidence and possible systemic effects apply to you.

You can also ask how the diagnosis was reached and whether examination with a Wood's lamp

or dermoscopy would change the choice. This is not about demanding every available test. It is about making sure that the next treatment is aimed at the pigmentation you actually have rather than at a generic idea of dark patches.

On Monday, arrange that conversation and use those three questions. The step takes a clinician who can assess your skin and a plan that makes room for relapse. You are not asking for a promise that melasma will never return. You are asking for a strategy that does not collapse when it does.

Where this comes from

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