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Patient Information for Levulan PDT

Levulan (aminolevulinic acid 20% is a natural occurring photosensitizing compound which has been approved by the FDA to treat pre-cancerous skin lesions called actinic keratoses. (AKs) Levulan is applied to the skin and subsequently 'activated' by wavelengths of light. This process of activating Levulan with light is termed Photodynamic Therapy (PDT)

The purpose of activating the levulan is to treat the AKs and it will simultaneously improve the appearance of the reduce acne rosacea, acne vulgaris, sebaceous hyperplasia, and decrease oiliness if the skin, to improve texture and smoothness by minimizing pore size. The improvement of these skin conditions (other than AK) is considered 'off –label' use of Levulan.

I understand that Levulan will be applied to my skin for _____ minutes. Subsequently, the area will be treated with a specific wavelength of light to activate the Levulan, following my treatment, I must wash off any Levulan on my skin. I understand that I should avoid direct sunlight for 48 hours following the treatment due to photosensitivity. I understand I am not pregnant.

Anticipated side effects of photodynamic therapy include discomfort, burning, swelling, redness and possible skin peeling: especially in any areas of sun damage skin pre-cancers of the skin, as well as lightening or darkening of skin tone and spots, and possible hair removal. The peeling may last many days, and the redness for several weeks if I have an exuberant response to treatment.

I consent to the taking of photographs of my face before each treatment session. I understand that I may require several treatment sessions spaced 4 weeks apart to achieve optimal results.

I understand that the medicine is not an exact science, and that there can be no guarantee of my results. I am aware that while some individuals have fabulous results, it is possible that this treatment will not work for me. I understand that there are alternative treatments including topical medications, oral medication, cryosurgery, and doing nothing. I have read the above information and understand it. My questions have been answered satisfactorily by the doctor rand his staff. I accept the risk and complications of the procedure. By signing this consent form I agree to have one or more PDT treatments.

_____

Patient Signature Date

_____

Physician Signature Date