WHAT IS YOUR SKIN TRYING TO TELL YOU?

The real causes behind eight common skin concerns — and what actually helps

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NO.1 URBAN AESTHETICS · NEWCASTLE-UNDER-LYME

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Eight concerns. One better question.

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FROM REBECCA

Adult acne that appears long after adolescence, pigmentation that deepens every summer and skin that is simultaneously oily, tight or suddenly intolerant of familiar products all have something in common: the mirror can show us that something has changed, but it cannot tell us why. Rebecca Beckett looks beyond the symptom to the biology beneath it, exploring when skincare helps, when professional treatment earns its place and when the wisest treatment is no treatment at all.

THE MIRROR SHOWS WHAT CHANGED. NOT WHY.

There is an extraordinary amount of skincare in the world for something most of us were once told simply needed soap, water and perhaps a little moisturiser when the weather turned cold. That old advice was hardly sophisticated, but the pendulum has now travelled very far in the other direction. We now know our ceramides from our peptides, debate retinoid percentages over coffee and have collectively developed opinions about the molecular weight of hyaluronic acid. A new ingredient can travel from an obscure laboratory paper to TikTok ubiquity before most people have worked out how to pronounce it. The beauty industry is very good at giving a name, a serum and an attractively frosted bottle to almost anything we would rather not see in the mirror.

Where it becomes less reliable is in explaining why that change appeared in the first place. A brown mark is labelled pigmentation, a collection of spots becomes acne, redness becomes sensitivity and roughness becomes texture. Those words are useful because they allow us to describe what we see, but they can also create the impression that every visible complaint is a single condition with a corresponding product waiting to correct it. Human skin, unfortunately for anyone hoping for a neat product-to-problem equation, is rarely that obliging.

The same redness can result from an impaired barrier, irritant dermatitis or rosacea. A skin that feels dry may actually be dehydrated, or it may genuinely be producing less sebum, or there may be an inflammatory skin condition sitting underneath both. Pigmentation may follow acne, accumulate gradually after years of ultraviolet exposure or behave like melasma, where hormones and light exposure create a very different pattern of disease. Even a fine line can mean several things depending on whether it disappears when the skin is hydrated, deepens with expression or remains because the underlying structure of the face has changed.

The useful question is not simply, “What can I use for this?” It is, “Why is my skin doing this?”

Skin is a living organ, not a surface waiting to be polished. It responds to ultraviolet radiation, hormones, inflammation, medication, genetics, environmental exposure, age, injury, stress and the ingredients we deliberately apply to it. More importantly, these things overlap. Acne can leave pigmentation. Attempts to treat acne too aggressively can damage the barrier. A damaged barrier can create redness and dehydration. Dehydration can make fine lines and texture look more obvious. Sun exposure can worsen pigmentation while simultaneously accelerating the collagen changes associated with ageing. The result is that one cause can create several visible complaints, while one complaint can arise from several very different causes.

That distinction changes the logic of sensible treatment, because the visible concern is only the beginning of the assessment rather than the answer to it. It is also why this is not going to be an article that matches eight skin complaints with eight products. Sometimes professional skincare is useful. Sometimes microneedling, a skin booster or another advanced treatment has a logical place. Sometimes the correct route is pharmacy treatment, your GP or a dermatologist. Sometimes the most effective intervention is stopping half of what is currently sitting on the bathroom shelf. The aim is not to make skincare more complicated. Quite the opposite. Once you understand what the skin is actually trying to tell you, a great deal of the noise becomes unnecessary.

When breakouts follow you into adulthood

Adult acne has a particular ability to feel unfair, not least because most of us assumed it would have been left behind with school photographs and questionable eyebrow decisions. Yet acne commonly persists into adulthood and, for some people, appears for the first time well beyond adolescence. What adult acne does not mean, despite an astonishingly persistent myth, is that somebody has failed to wash their face properly. Acne develops within the pilosebaceous unit - the hair follicle and its associated sebaceous gland. Sebum production, abnormal shedding of cells within the follicle, inflammation and the activity of Cutibacterium acnes, which normally lives on human skin, all play a part. The follicle becomes blocked, inflammatory signalling increases and the familiar collection of comedones, papules, pustules or, in more severe disease, nodules and cysts can follow.

That process is taking place within the follicle. It cannot simply be scrubbed away from the surface. In fact, trying to do exactly that is one of the easiest ways to make already unhappy skin unhappier. Adult acne is often influenced by hormones because sebaceous glands respond to androgen signalling. This helps explain why some women notice cyclical flares around menstruation and why acne can alter with pregnancy, contraception, perimenopause and other hormonal changes. Genetics matters too. Certain medicines can contribute. Occlusive products, friction and sweating may aggravate acne-prone skin, while stress can interact with inflammatory signalling, sleep and behaviour in ways that make an existing tendency more troublesome.

That does not mean every jawline spot can confidently be blamed on “hormones”. Nor does it mean somebody needs an expensive hormone test because Instagram has decided they have a cortisol face. This is why the pattern matters as much as the presence of the spots themselves. Acne that appears suddenly in adulthood alongside irregular periods, increased facial or body hair or other features suggesting androgen excess deserves appropriate medical assessment. So does acne that is severe, painful, rapidly scarring or significantly affecting confidence and mental wellbeing. This is an important distinction because acne straddles the world of skin health and medicine. A professional facial may support acne-prone skin, but moderate or severe inflammatory acne is not a facial problem.

Current NICE guidance, updated in April 2026, sets out evidence-based treatment pathways for acne and recognises the importance of preventing scarring and addressing psychological impact. Depending on severity and the individual, medical treatment can include agents such as benzoyl peroxide, topical retinoids, azelaic acid and combinations with antimicrobial therapy. More severe disease may require escalation through primary care or dermatology.

ADULT ACNE / CONTINUED

> *First control the disease. Then decide what, if anything, needs to be done about the evidence it left behind.*

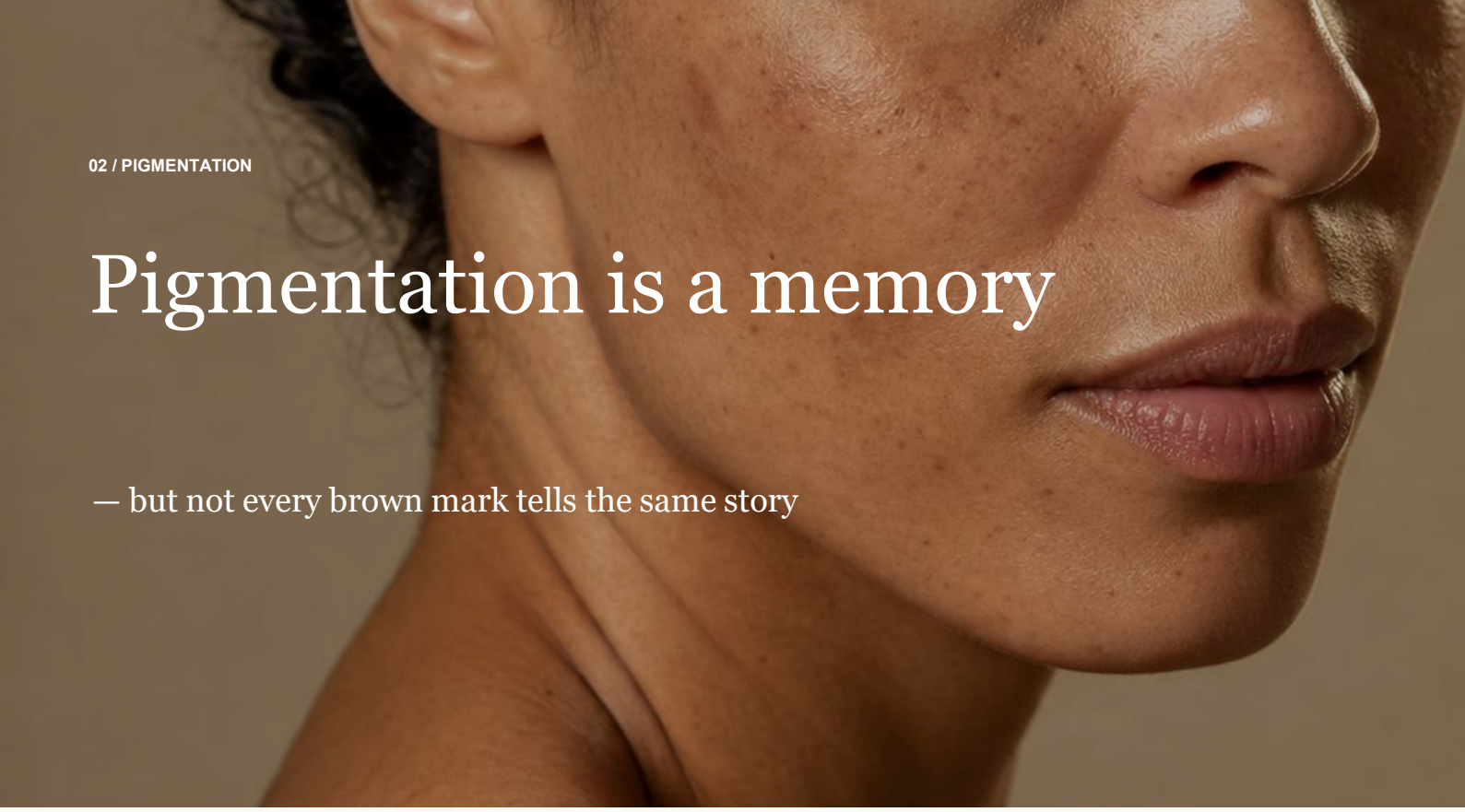
Professional skincare can still be useful, but its role is to create a better environment around appropriate acne treatment rather than impersonate it. A gentle routine that cleanses effectively without stripping the skin, manages excess oil without trying to desiccate the face and supports barrier function is considerably more useful than mounting a chemical assault every evening. Professional treatments such as Dermalogica Pro Clear can have a place for appropriately assessed acne-prone skin, particularly where congestion and oil imbalance are significant, but the treatment should sit within the broader picture rather than pretending to replace it.

The idea that oily skin should simply be “dried out” is where otherwise sensible routines often begin to unravel. Oil and water are not opposites in quite the way skincare advertising has sometimes implied. A person can have significant sebum production and still have a compromised barrier with excessive water loss. The result is skin that can appear oily across the central face while simultaneously feeling tight, flaky or sore. Add repeated acids, exfoliating pads, foaming cleansers and alcohol-heavy toners, and the person may end up treating inflammation with more inflammation.

There is also a curious tendency to respond to acne by repeatedly changing the routine. A treatment is used for eight days without dramatic improvement, another active is added, a viral serum joins it, and when the skin becomes irritated a collection of soothing products arrives without the original irritants ever leaving. Before long it becomes almost impossible to know whether the acne itself is changing or whether the skin is simply reacting to the treatment strategy. Acne treatment is rarely cinematic. It is usually methodical and irritatingly patient. That matters because the timescale for biological improvement is measured in weeks and months, not the length of a Reel.

Diet deserves the same degree of restraint. There is ongoing research into relationships between dietary patterns and acne, but NICE does not currently recommend a specific acne diet. That is a useful corrective to the increasingly confident social-media suggestion that dairy, chocolate, gluten or yesterday's latte can explain every breakout. Nutrition matters enormously to health, but acne deserves better than turning somebody's face into a judgement about what they ate. Scarring is the other reason persistent inflammatory acne deserves to be treated with some urgency rather than endless experimentation. One of the strongest arguments for taking persistent inflammatory acne seriously is that the consequences can remain long after the active spots have settled. The earlier inflammation is controlled, the better the opportunity to reduce the risk of permanent scarring.

This is also why I would not rush straight to microneedling simply because acne and microneedling appear on the same treatment menu. Microneedling can be valuable later for selected atrophic acne scars. It is a very different proposition while significant inflammatory acne remains active. First control the disease. Then decide what, if anything, needs to be done about the evidence it left behind.



Pigmentation is a memory

— but not every brown mark tells the same story

Pigment is, in many ways, the skin remembering what has happened to it. That memory may be of sunlight, inflammation or hormonal change, and occasionally what looks like an ordinary area of pigmentation is not something a beauty clinic should be treating at all. Melanin is produced by melanocytes and transferred into surrounding skin cells, where it contributes to skin colour and, importantly, helps protect against ultraviolet radiation. Uneven pigmentation appears when that production or distribution becomes altered. The visible result may be similar - a darker patch of skin - but the pathway behind it can be completely different.

That matters because pigment is one of those areas where enthusiastic treatment can easily become counterproductive. Consider the familiar sun spot. Ultraviolet exposure stimulates melanogenesis and, over years, produces cumulative changes that often become more obvious with age. The skin keeps a surprisingly detailed record of summers spent without much sun protection, sunbeds used decades ago and everyday exposure that never felt significant enough to count. This is why pigmentation frequently appears to worsen after summer even when there has been no memorable episode of sunburn. UV does not require a dramatic holiday incident to influence the skin.

For this type of pigmentation, photoprotection is not the dull preliminary before the “real” treatment. It is the treatment upon which everything else depends. Attempting to lighten sun-driven pigmentation while allowing continued UV stimulation is a little like trying to dry the bathroom floor without turning off the tap. Post-inflammatory hyperpigmentation tells a different story because the pigment follows an episode of inflammation or injury rather than accumulating primarily through light exposure. Here, the pigmentation develops after inflammation or injury. Acne is one of the common triggers, but dermatitis, burns, picking, irritation and professional procedures can all leave an area darker than the surrounding skin. Inflammation stimulates melanocytes and increases melanin production; where injury reaches deeper structures, pigment can persist at different levels of the skin.

This response occurs in all skin tones but can be more pronounced and longer-lasting in darker skin. It is also one of the reasons treatment planning has to respect skin colour rather than assuming that the same intensity of peel or procedure should be used on everyone. Where inflammation helped to create the pigment, deliberately creating unnecessary additional inflammation is not an especially intelligent treatment strategy. The third pattern many people encounter is melasma, which deserves to be separated from both simple sun spots and post-acne pigmentation. Melasma typically appears as symmetrical brown or grey-brown patches, often over the cheeks, forehead, upper lip or nose. Hormonal influence is important, which is why it is associated with pregnancy and can be influenced by hormonal medication, although men can develop it too.

Light exposure is central to the behaviour of melasma and is one reason the condition so often proves more persistent than a straightforward sun spot. The British Association of Dermatologists describes UV exposure as an important trigger and notes that high-energy visible light may contribute too. What the BAD is careful to point out - and what the internet tends to leave out - is that this is not evidence that staring at your telephone is causing melasma. It is a useful example of the difference between what the evidence actually says and what makes a more dramatic headline.

DIAGNOSIS BEFORE CORRECTION

Melasma can improve considerably, but it also has a tendency to recur. Anybody selling a permanent “melasma removal” should therefore prompt a degree of scepticism. The more realistic approach is management. Consistent broad-spectrum sun protection is fundamental. Depending on the individual, pigment-modulating ingredients, prescription treatments and carefully selected professional procedures may have a place. Visible-light protection can be considered in melasma, particularly through suitable tinted sunscreens containing iron oxides.

In clinic, superficial uneven tone may respond well to a personalised brightening programme, professional exfoliation or a Dermalogica Pro Bright approach. Microneedling can sometimes be incorporated into a wider plan, particularly where pigmentation coexists with textural concerns, but this is precisely the sort of treatment that should follow assessment rather than precede it. The strongest treatment is not automatically the best treatment. Pigmentation-prone skin has a long memory for poor decisions. There is another reason to slow down before treating a brown mark, and it has nothing to do with beauty.

A changing mole, however, is not pigmentation waiting for a peel; it belongs in a medical assessment pathway before any cosmetic treatment is considered. The NHS advises medical assessment for a mole that changes size, shape or colour, becomes painful or itchy, bleeds, crusts or becomes inflamed, and for a new or unusual mark that does not disappear after a few weeks. Those are not areas to “see how they respond” to cosmetic treatment first.

The responsible order is diagnosis before correction. It is the difference between treating colour and understanding why that colour exists.

Redness is a colour, not a diagnosis

Red skin has perhaps suffered more from the language of “sensitivity” than almost any other concern. Sensitivity sounds reassuringly simple. It also covers an enormous amount of territory. The face may flush after heat or exercise. Products may suddenly sting. There may be persistent redness across the cheeks and nose, tiny visible vessels, dry patches, itching or acne-like bumps. Each of those can be described as sensitive skin, yet they may represent barrier disruption, irritant contact dermatitis, allergic contact dermatitis, rosacea or an entirely different inflammatory process. The most fashionable explanation at present is often “damaged skin barrier”, and sometimes that is exactly what is happening.

The outermost layer of the epidermis, particularly the stratum corneum, is a remarkably effective interface between the body and the outside world. It limits water loss while helping prevent irritants, allergens and microorganisms gaining easy access to deeper tissue. Its function depends on organised corneocytes surrounded by a lipid matrix containing substances including ceramides, cholesterol and fatty acids. When that system is disrupted, transepidermal water loss can increase and skin that previously tolerated ordinary products can become tight, dry, red or sting on application. Unfortunately, modern skincare has developed a slightly unhealthy admiration for visible evidence that a product is doing something. A tingling acid must be powerful. A peeling retinoid must be effective. A face that feels tight after cleansing must be extremely clean.

This is where enthusiasm for active skincare can become expensive, both financially and in terms of barrier function. A well-formulated active ingredient used intelligently can be enormously useful. The same ingredient, layered with three other actives onto already irritated skin because a seven-step routine looked convincing online, can turn into the problem. Persistent burning should not be interpreted as proof that a product is performing particularly well. There is a difference between expected temporary adjustment to a particular active and ongoing inflammation. Contact dermatitis adds another layer. Irritant contact dermatitis occurs when a substance directly damages the outer layer of the skin; allergic contact dermatitis involves an immune response to a specific allergen. Cosmetics can contribute through fragrances, preservatives and other ingredients, while soaps, detergents, solvents and repeated exposure to water are recognised irritants.

Interestingly for those of us working in Staffordshire and other hard-water areas, NHS guidance specifically includes hard, chalky water among potential irritants in susceptible people. That does not mean the local water supply is secretly causing everybody's facial redness. It does mean environment belongs in the history when skin has become persistently irritated.

GOOD AESTHETICS SOMETIMES LOOKS LESS LIKE DOING SOMETHING AND MORE LIKE KNOWING WHEN TO STOP.

Rosacea introduces another, rather different, explanation for facial redness and reactivity. Rosacea is a chronic inflammatory condition that primarily affects the face. It can begin with flushing and progress to more persistent redness, visible vessels and inflammatory bumps or pustules. The skin may burn or sting. In some people the eyes are affected too. Its exact cause is not fully understood. Genetic, immune and environmental factors all appear to contribute, and individual triggers can include sunlight, temperature extremes, alcohol, hot drinks, spicy food, exercise and stress. The word trigger is important. Those things can worsen rosacea in somebody who has it. That is not the same as saying a glass of wine or stressful Wednesday created the condition.

Rosacea can also be mistaken for acne, especially when inflammatory papules and pustules are present. This is where simply buying stronger “spot treatments” can go wrong because many aggressive acne products are poorly tolerated by rosacea-prone skin. The British Association of Dermatologists recommends gentle cleansing, non-perfumed moisturising, regular sun protection and identification of individual triggers. Prescription topical or oral treatment may be needed for inflammatory rosacea, and vascular treatments can sometimes address persistent vessels and redness.

In a professional skin setting, calming and barrier-supportive treatment can have a useful place where the concern is sensitivity or barrier dysfunction. A Pro Calm or tailored ProSkin treatment should feel like precisely that - a reduction in unnecessary provocation, not an opportunity to squeeze in one more active because the appointment has already been booked. Where I think skincare gets this right is when it restores tolerance. Where it gets it wrong is when we continue throwing soothing products over a routine that is still causing the irritation. If six products sting and the seventh promises to calm the sting, the seventh product may not be the breakthrough. Sometimes the breakthrough is removing the first six.

There is also a clinical line that should not be blurred. Persistent or severe dermatitis requires appropriate medical assessment, and rosacea affecting the eyes deserves particular attention. Painful eyes, significant grittiness, light sensitivity or visual disturbance are not cosmetic symptoms.

Good aesthetics sometimes looks less like doing something and more like knowing when to stop.

04 / DRY, DEHYDRATED AND DULL

Three words that are not interchangeable

The skincare industry sells hydration with almost operatic enthusiasm, which is perhaps why the language around dry and dehydrated skin has become so muddled. There are water creams, moisture clouds, sleeping masks, essences, mists, hyaluronic serums and moisturisers promising to drench, flood or quench skin in ways that make the average face sound as though it has crossed the Sahara without a bottle. Yet dry and dehydrated skin remain among the most common concerns. One reason is that we continue to use the words as though they describe the same thing.

Those two words do not describe the same biological problem. Dry skin generally refers to insufficient surface lipids or sebum. It may feel rough, tight or flaky and is often associated with reduced barrier efficiency. Dehydration describes insufficient water within the outer layers of the skin and excessive water loss through the barrier. That distinction explains an apparently contradictory skin type that causes endless confusion: oily skin that also feels dehydrated. Sebum is oil. Hydration is water. A face can produce plenty of the first while struggling to retain the second.

This is the skin that becomes shiny across the forehead and nose by lunchtime yet feels tight after cleansing. Makeup separates around dry patches while congestion persists elsewhere. The understandable instinct is often to treat the oil more aggressively, which strips the barrier further, increases discomfort and makes the entire picture more difficult to interpret. Environment plays a significant part in dehydration. Cold weather, low humidity, central heating, air conditioning and repeated hot bathing can all influence water loss from the skin. So can skincare itself. Harsh cleansing, excessive exfoliation and poorly tolerated actives disturb the very structure responsible for keeping water where it belongs.

Age alters that environment too. Sebum production, epidermal turnover and the lipid composition of the barrier change as skin matures, and hormonal changes through perimenopause and menopause can be particularly noticeable. Skin that once tolerated a very light moisturiser and frequent exfoliation may simply behave differently a decade later. When that happens, it is not necessarily a case of the product “stopping working”; it may simply be that the skin it was chosen for has changed. There is another beauty word sitting alongside dryness and dehydration: dullness.

Dull skin is not really a diagnosis at all. Usually it describes a loss of even light reflection. A rough or dehydrated surface scatters light rather than reflecting it smoothly. Uneven pigmentation contributes. So does accumulated surface scale. The result is skin that appears tired or flat even when there is nothing medically wrong with it. This explains why some professional treatments produce an immediate glow. Exfoliation and hydration can make the surface more regular and therefore more reflective. It is an optical improvement. That does not make it fraudulent; it simply means we should not pretend every immediate glow represents deep structural regeneration.

HYDRATION / CONTINUED

Advanced treatment should build upon good foundations — not substitute for them.

Drinking water deserves some attention here because it has acquired an almost mythical status in online skincare advice. Of course adequate hydration matters to general health. Somebody who is genuinely dehydrated should correct that. But a compromised facial barrier is not repaired simply by adding another litre to the daily water bottle. The more useful question is whether the skin can retain the water already available to it. Humectants attract water. Emollients smooth and soften the spaces between cells. Occlusive ingredients reduce evaporation. Barrier-supportive lipids help restore structure. A good moisturiser does not need a fantastical name. It needs a formulation that makes sense for the skin using it.

This is also an area where professional treatment can be very satisfying because several mechanisms may be addressed in a single plan. A tailored ProSkin treatment can combine careful exfoliation, hydration and barrier support. LuminFusion may be appropriate where luminosity and superficial refinement are priorities. Injectable skin boosters occupy a different category entirely and can improve hydration and aspects of skin quality in appropriately selected clients. What an injectable cannot do is compensate for a routine that strips the skin twice a day, which is why advanced treatment should sit on top of sensible foundations rather than replace them.

Advanced treatment should build upon good foundations, not substitute for them. If skin is visibly inflamed, sore, persistently cracked or behaving in a way suggestive of eczema or dermatitis, that is also the point at which the conversation moves away from “which facial?” and towards appropriate medical assessment. The cleverest treatment plan is sometimes remarkably unglamorous: gentle cleansing, an appropriate moisturiser, SPF and time. Beauty marketing may struggle to make a campaign out of that. Skin tends to appreciate it.

NEXT / PROFESSIONAL SKIN, SUPERCHARGED

dermalogica

LUMIN FUSION

SUPERCHARGED LUMINOSITY THAT LASTS

Professional skin treatment · No downtime

dermalogica

PRO MICRONEEDLING

Controlled treatment for selected lines, texture and scarring concerns — following individual assessment.

05 / PORES AND TEXTURE

The pursuit of completely smooth skin

> *Expect improvement, not a digitally poreless face. Normal anatomy is not an imperfection to erase.*

PORES ARE MEANT TO BE THERE.

Pores have been opened, closed, steamed, iced, vacuumed, detoxified and blurred by so many generations of beauty products that it is worth establishing one slightly disappointing fact. Pores are meant to be there, because they are part of normal skin anatomy rather than tiny defects waiting to be sealed. A pore is an opening associated with a follicle. It is part of normal skin anatomy, not a defect that can be permanently sealed. What can change is the visibility of the pore, which is influenced by the follicle itself and by the condition of the tissue surrounding it.

Genetics has a considerable influence. Sebum production matters. A follicle containing excess oil and keratinous material can appear more prominent. Sun-related damage and age-related changes in the collagen and elastic structures surrounding follicles can make the opening look larger because the tissue supporting it is less firm. This is why somebody who never worried about pores at twenty-five may notice them increasingly in their forties despite cleansing exactly as they always did. The pore itself has not suddenly become badly behaved. Its surroundings have changed. Congestion can also exaggerate texture. Blackheads, or open comedones, are often misinterpreted as dirt sitting within the skin. Their dark appearance results primarily from oxidation of material exposed at the follicular opening rather than somebody having failed to cleanse thoroughly enough.

That matters because it explains why scrubbing at them is such an unsatisfactory strategy. The problem is within the follicle. Appropriate cleansing helps remove surface oil and debris, but normalising shedding within the follicle is often more useful. Depending on the person and their overall routine, ingredients such as salicylic acid and retinoids may have a place. Again, tolerance matters. The object is not to prove how many active ingredients one face can survive simultaneously. “Texture” is an even broader term than pores and can describe several quite different things that happen to produce an irregular surface.

It may describe closed comedones. It may be roughness caused by dehydration. It may reflect photodamage. It can mean very fine superficial lines, sebaceous filaments, acne scars or simple anatomical variation that only became a “problem” after somebody viewed their skin through a magnifying mirror under a bathroom spotlight. This is where social media has been particularly unkind. High-resolution cameras, ring lights and filters have created an aesthetic in which actual human skin is increasingly compared with digitally altered skin rather than other human skin. No procedure can compete fairly with software, nor should a responsible treatment plan attempt to do so.

The objective with pores and texture should therefore be improvement where there is something meaningfully treatable: reduce congestion, improve hydration, refine an excessively rough surface and, where appropriate, stimulate structural remodelling. Professional exfoliation can be useful for superficial roughness and congestion. A personalised ProSkin treatment allows that intensity to be adjusted rather than assuming every face needs the same acid at the same strength. When the concern sits deeper - for example, certain acne scars, fine lines or age-related textural change - microneedling becomes more interesting because it works through controlled micro-injury and the subsequent repair response.

A 2025 systematic review of microneedling for facial rejuvenation found high patient satisfaction and relatively low rates of reported adverse effects across the available studies, while also pointing out something that deserves more attention: research protocols and outcome measures remain inconsistent. In other words, there is legitimate evidence supporting microneedling as a rejuvenation technique, but evidence does not turn it into magic.

Expect improvement, not a digitally poreless face. Normal anatomy is not an imperfection to erase.

06 / AGEING INTELLIGENTLY

Ageing is several things at once

There is a point at which skin begins to hold on to evidence of time in ways that are subtle at first and then suddenly rather obvious. A pillow crease lingers longer in the morning. Foundation behaves differently around the eyes. The neck seems suddenly to have joined the conversation. Fine lines remain visible even after the face relaxes and the skin feels thinner, less springy or simply not quite as resilient as it used to. All of this tends to be filed under the single heading of “ageing”, although biologically that is an enormous oversimplification.

Skin ageing is usually understood as an interaction between intrinsic ageing - the changes that occur with time - and extrinsic ageing, created or accelerated by environmental exposure. Ultraviolet radiation is the major external driver, which is why decades of intermittent exposure eventually reveal themselves as more than pigmentation. UV affects collagen, elastin and other components of the extracellular matrix. It influences pigmentation and surface texture and contributes to the characteristic changes we call photoageing. This is the profoundly unsexy reason sunscreen continues to outperform almost every extravagant anti-ageing claim. Preventing avoidable damage is easier than attempting to reverse it later.

Collagen is important, but it is only one part of a much larger structural story. As we age, epidermal turnover changes. Barrier function and hydration can change. Collagen organisation and quantity alter, elastin changes, and deeper structures beneath the skin evolve too. Facial fat compartments change. Ligaments stretch. Bone remodels. Repetitive muscular movement continues to fold the skin in familiar places. Hormonal change adds another layer, particularly for women through perimenopause and menopause, when shifts in hydration, barrier function and dermal structure can become especially noticeable. The visible face at fifty is therefore not simply the face at thirty with “less collagen”. It is an altered biological and structural system.

That has practical implications because different lines require different thinking. A fine superficial line exaggerated by dehydration is not the same as an expression line repeatedly folded by muscle movement. Neither is identical to a static fold created partly by loss of deeper structural support. This is why the phrase “best treatment for wrinkles” is almost meaningless without looking at the wrinkle. If the primary issue is poor hydration and crepey texture, skin-quality treatment may make sense. If repetitive movement is the dominant mechanism, reducing that movement may be more relevant. If structural volume has changed, treating only the epidermis will have obvious limits.

Good aesthetics should therefore work backwards from anatomy rather than forwards from whichever treatment happens to be most visible on the menu. That principle is particularly important as the market becomes increasingly crowded with treatments promising “regeneration”. The word is attractive because it suggests the skin is somehow rebuilding itself from within, which in some contexts is biologically plausible. But it is also being used so widely that it risks becoming the next “detox”: a scientific-sounding word stretched far beyond its useful definition.

AGEING / CONTINUED

Consistency tends to beat intensity.

Microneedling has a clear rationale here. Controlled micro-injury initiates wound-healing pathways and collagen remodelling, which is why it can be useful for fine lines, textural change and selected forms of scarring. The changes are progressive rather than immediate; the inflammatory glow immediately after treatment is not the end result, and meaningful remodelling continues during the following weeks and months. Skin boosters address a different mechanism. Hyaluronic-acid-based injectable treatments may improve hydration and aspects of superficial skin quality in suitable clients. They are not filler in the traditional sense of replacing significant volume, nor do they stop dynamic muscular movement.

Professional skincare occupies another layer: retinoid-based strategies where appropriate, antioxidants, sensible exfoliation, moisturisation and, once again, regular sunscreen. These approaches can complement one another precisely because they are doing different biological jobs, and that is a much more useful way to think about combination treatment than simply adding procedures together.

Perhaps the most useful thing I can say about ageing skin, however, is that it often benefits from greater intelligence rather than greater aggression. The moment people notice ageing, they frequently start escalating. A stronger retinoid is purchased. An acid is added. Vitamin C becomes more concentrated. Exfoliation becomes more frequent. Then the eye cream, peptide serum, exfoliating toner and overnight mask arrive because apparently we are now in a race against time. Skin that has become less resilient does not necessarily appreciate that sense of urgency and may tolerate escalation less well than it once did.

This is where consistency tends to beat intensity. A moderate routine that can be comfortably maintained for a year will generally be more valuable than an extraordinary routine used for eleven days before the barrier objects. It also helps to decide what we are actually trying to achieve. I have very little interest in describing normal ageing as a disease. The existence of a line at fifty is not evidence that somebody has failed to look after themselves. There is a meaningful difference between improving skin quality and attempting to erase every sign that a person has lived. Healthy ageing allows texture, movement and expression to remain. It simply gives the skin the best chance of ageing well. That is a much more appealing objective than trying to freeze it at an arbitrary birthday.

> *Healthy ageing allows texture, movement and expression to remain.*

07 / ACNE SCARRING

When acne has gone but left its architecture behind

Acne scarring illustrates perfectly why one visible category can contain several different biological problems, each of which may respond to a different intervention. The breakout may have resolved months or years ago, yet depressions, changes in texture and areas of pigmentation remain. It is tempting to treat all of that as one concern called “acne scars”. That label is convenient, but it is not a single condition. Post-inflammatory hyperpigmentation may be sitting alongside genuine structural scars, and the scars themselves can have different morphologies. Atrophic acne scars develop when inflammatory damage and wound healing leave a deficit of collagen in the dermis. Ice-pick scars are narrow and deep. Boxcar scars are broader, with relatively defined edges. Rolling scars create an undulating surface, often because fibrous tethering pulls the skin downward.

Hypertrophic and keloid scars behave in the opposite direction, producing raised tissue. The distinction is more than cosmetic semantics because scar morphology helps predict which treatments are likely to help and which are unlikely to be enough on their own. Microneedling can be useful for selected atrophic scars because repeated controlled injury encourages remodelling. A 2024 network meta-analysis examining randomised studies of microneedling and combination treatments for acne scars found meaningful benefit across microneedling approaches, with some combination strategies outperforming microneedling alone.

That does not mean every depressed scar should automatically be needled. Deep ice-pick scars may respond better to other techniques. Tethered rolling scars can require treatment aimed specifically at releasing that tethering. Raised scars need an entirely different strategy. The individual's skin matters just as much as the scar itself, particularly where there is a history of pigmentary change, keloid formation or poor tolerance of inflammatory procedures. Some people are particularly prone to post-inflammatory pigmentation, and darker skin tones require careful treatment planning to reduce unnecessary inflammatory complications. Previous keloid formation matters. So does whether the acne is genuinely controlled.

I would always separate those two stages: first, stop creating new scars. Then assess the scars that remain. The emotional part of acne scarring deserves mentioning too because it is easy to talk about “texture” in the abstract while forgetting that some people have spent years arranging hair, makeup, photographs and lighting around it. Treatment can make a significant difference, but what I would not promise is erasure, because scar tissue is altered tissue and the realistic goal is improvement in depth, texture and the way light falls across the surface. Scar tissue is altered tissue. The sensible aim is meaningful improvement in depth, texture and how light falls across the surface. That may take a course of treatment, because collagen remodelling is gradual.

The best scar plan is rarely the one that promises the fastest transformation. It is the one that properly identifies what sort of scar is actually there.

When the shelf becomes more sophisticated than the skin

There is a strange moment in skincare when the shelf becomes significantly more sophisticated than the skin and the routine acquires a complexity that no longer seems to correspond with better results. There is a morning cleanser and an evening cleanser, although nobody can now remember what the first cleanser did wrong. There is vitamin C, niacinamide, hyaluronic acid, two peptides, an exfoliating toner, a BHA, an AHA and a retinoid that lives on an elaborate rotation because somebody made a skin-cycling diagram. None of the products is necessarily bad. The problem is that nobody is quite sure what each one is now supposed to be doing.

This is often described as skincare “stopping working”, but there are several more interesting possibilities. The first possibility is simply that the skin has changed while the routine has remained fixed. A routine designed for oily skin in somebody's late twenties may genuinely be wrong fifteen years later. Hormonal environment changes. Sebum changes. Life changes. Medication changes. Years of sun exposure accumulate. Pregnancy, menopause and illness alter the context in which skin behaves. Products do not operate independently of the person using them, so a routine that was perfectly sensible years ago can become increasingly ill-suited as that person and their skin change.

The second possibility is that the original problem was never quite what the person thought it was, which is surprisingly common when several conditions share similar surface features. This is surprisingly common because skin conditions borrow one another's vocabulary. Rosacea can look like acne. Dermatitis can be mistaken for ordinary dryness. Barrier disruption can be mistaken for sensitivity requiring yet another soothing serum. Melasma can be treated as though it were straightforward sun pigmentation. Dehydration lines are attacked as established wrinkles. A perfectly good product can therefore fail simply because it is being asked to solve the wrong problem.

The third possibility is sheer excess, particularly when ingredient literacy turns into the assumption that every effective ingredient should appear somewhere in the same routine. Ingredient literacy has been one of the best developments in modern skincare. People are more informed than ever about retinoids, acids, peptides and sunscreen. The unintended consequence is that knowing an ingredient is effective can easily become believing it should be used. All of it. Preferably tonight. Formulation, concentration and frequency all matter, as do the other products in the routine and the condition of the skin barrier at the point they are being used.

There is, after all, no skincare medal awarded for completing the entire periodic table before bed. When skin becomes tight, glossy, flaky, red and increasingly reactive, I am much more interested in taking things away than finding the next heroic ingredient to put back in. That principle is not particularly commercial, but it is sound. If contact dermatitis is being driven by an irritant, NHS advice centres on identifying and avoiding the irritant and supporting the skin appropriately. Buying progressively more sophisticated moisturisers while continuing exposure to the cause is unlikely to be a winning strategy. The same logic applies to an over-treated routine: simplify it, allow inflammation to settle and then rebuild deliberately rather than immediately replacing everything that has been removed.

THE ROUTINE RESET

Skincare should eventually become rather boring.

THAT IS USUALLY A GOOD SIGN.

The fourth possibility is less glamorous but just as important: the routine may simply not have been given enough time to produce a biological change. Real skin biology has a deeply inconvenient relationship with impatient humans, because the processes we are trying to influence generally move far more slowly than advertising does. Acne medication generally needs weeks before meaningful improvement can be judged. Pigmentation requires sustained management. Collagen remodelling after microneedling occurs over months. Retinoid strategies reward consistency. Barrier recovery is not necessarily complete because redness reduced after three days.

Before declaring something useless, we should ask whether it has been used correctly and for an appropriate period. This is one reason before-and-after culture can distort treatment decisions. The internet rewards suddenness. A six-month improvement achieved through consistency is less exciting than “THIS CHANGED MY SKIN OVERNIGHT”, even when the former is considerably more believable. There is also a psychological trap in constantly searching for a missing product. Every new purchase creates a fresh burst of hope that this serum, this molecule or one more addition will finally produce the skin shown in the campaign photograph, even when the real problem is that the routine has never been allowed to settle into anything coherent.

Sometimes the most useful professional skin consultation is not the one that recommends something new. It is the one that looks at everything already being used and asks each product to justify its existence. The useful questions are wonderfully ordinary: why is this product here, what problem is it treating, is there evidence for that approach, is the skin tolerating it, does it duplicate something else, and what actually happens if we remove it? A skin plan becomes much easier to follow when every step has a purpose. I would rather somebody own four products they understand and use consistently than fourteen they apply according to whichever TikTok they watched most recently. Skincare should eventually become rather boring. That is usually a good sign.

ASK EVERY PRODUCT TO JUSTIFY ITS EXISTENCE.

ASSESSMENT FIRST

The treatment is not the starting point

This is where the eight concerns come back together, because each of them exposes the same weakness in treatment-first thinking. Beauty is often sold to us treatment-first: choose the facial, peel, injectable or serum, and then find the problem it promises to improve. Clinical thinking works in the opposite direction, beginning with the concern and only reaching the treatment after the likely mechanism and important exclusions have been considered. That means defining the concern, considering the likely mechanism, excluding anything that does not belong in an aesthetic pathway and correcting the fundamentals before deciding whether professional treatment adds enough value to justify doing it.

That order sounds obvious when written down, yet it is remarkably easy to reverse once a menu of attractive procedures enters the room. Take pigmentation. If UV exposure is continuing unchecked, photoprotection matters before a brightening procedure. Take acne scarring. Active inflammatory disease needs controlling before embarking on a scar-remodelling course. Take dehydrated skin. Barrier support belongs ahead of an aggressive resurfacing treatment. Take a changing pigmented lesion. Medical assessment belongs before everything. None of those decisions diminishes professional skin treatment; on the contrary, they make it considerably more credible because treatment is being chosen for a reason rather than simply because it is available.

This is the principle behind how I prefer to approach skin at No.1 Urban Aesthetics in Newcastle-under-Lyme. A Dermalogica treatment can be genuinely useful when professional exfoliation, congestion management, hydration or barrier support is required. Pro Clear, Pro Bright and Pro Calm are useful precisely because the treatment can respond to different skin states rather than assuming every client needs the same facial. Microneedling has a different role. Its value lies primarily in controlled tissue remodelling, making it relevant to selected acne scars, textural concerns and features of skin ageing.

Skin boosters again do something different, focusing on injectable hydration and aspects of skin quality in clients for whom they are appropriate. There are also occasions when none of those treatments is the correct first answer and the consultation should end somewhere else entirely. That may mean pharmacy advice, a GP or dermatology, or simply allowing an irritated barrier to recover before spending money on anything advanced. Good skin practice should be comfortable with all of those outcomes. What concerns me more is a model in which every consultation somehow ends with exactly the treatment the clinic happens to sell. Human skin is far too varied for the answer to be that predictable.

THE LOCAL CONTEXT

There is no Newcastle-under-Lyme skin type.

BUT WHERE WE LIVE STILL MATTERS.

Cold winters
Low humidity
Central heating
Hard water
Everyday UV

There is no Newcastle-under-Lyme skin type - but where we live still matters

Location does not fundamentally change human skin biology, and I am not going to invent a special Staffordshire epidermis for the sake of local SEO. There are, however, ordinary environmental factors that influence how skin behaves, and local context can be useful when it reflects a person's actual life rather than being added as a search-engine decoration. Cold winters, low humidity, indoor central heating and rapid shifts between outdoor weather and heated buildings can aggravate dryness and dehydration. Hard water can contribute to irritation in susceptible skin, particularly where dermatitis already exists. Summer ultraviolet exposure matters even when the temperature feels unimpressive, because UV intensity and heat are not the same thing.

This is why a skin plan should work in someone's actual life rather than in an abstract laboratory. Someone commuting between Newcastle-under-Lyme and Stoke-on-Trent, spending the day in centrally heated or air-conditioned environments and then layering multiple active products every evening may have very different practical needs from the person represented in a skincare campaign photographed beside the Mediterranean. Local care is useful when it adds context, not when a postcode is simply stuffed repeatedly into a paragraph for Google. The search engine can have Newcastle-under-Lyme. Your face gets a proper assessment.

The search engine can have Newcastle-under-Lyme. Your face gets a proper assessment.

Normal skin has pores. Texture. Lines. A history.

There is something I think the beauty industry needs to become much better at saying, particularly as filtered images continue to alter our idea of what untreated skin should look like. Normal skin has pores and texture, changes through the month and through the year, develops lines where a face moves and may carry freckles, scars, pigment or evidence of previous inflammation; above all, it ages because that is what living tissue does. None of those things automatically requires treatment, even though any of them can become a reasonable treatment concern when it genuinely bothers the person living with it.

That does not make professional aesthetics contradictory. Wanting healthier skin, improving acne scarring, managing troublesome pigmentation or choosing to soften features of ageing are perfectly reasonable decisions. The distinction lies in the objective and in whether we are trying to improve a genuine concern or chase an image of skin that does not exist outside software. If the benchmark is filtered skin, every real face will eventually appear to fail it. If the benchmark is healthier function, improved texture, controlled inflammation, appropriate hydration, more even pigmentation and skin that somebody feels comfortable living in, modern skincare and aesthetic medicine can do a great deal. The useful skill is knowing what can realistically be changed, what should be managed rather than “cured”, and what is simply normal skin that should be left alone.

For me, the hierarchy is simple: protect skin from preventable damage; treat disease as disease; restore the barrier when it is compromised; use evidence-based ingredients consistently; choose professional treatments because their biological mechanism matches the concern rather than because they are fashionable; refer when something falls outside our scope; and leave normal skin alone when it does not need fixing. None of this has the instant gratification of discovering a miraculous new serum. It does have one advantage. It works with the skin rather than continually fighting it.

FINAL WORD

Your skin is not a trend

We know more about skincare than any generation before us, which ought to have made the whole subject simpler rather than more anxious. Instead, for many people, it has created the sense that every patch of texture needs an acid, every line needs an injectable, every pore requires intervention and every unremarkable change in the skin is evidence that something has gone wrong. The answer is not to abandon modern skincare. There is excellent science behind many of the ingredients and treatments available now, and professional skin treatment can achieve results that would have been unrealistic only a generation ago.

The answer is to become more selective about what deserves our attention and more demanding about the reason for every treatment we choose. If your skin suddenly changes, become curious before becoming corrective: consider what has changed around it, look at the entire routine rather than the newest product, remember that redness, pigmentation, dryness, spots and texture are descriptions rather than diagnoses, and give sensible treatments enough time to work while retaining enough respect for the skin to recognise when it is asking you to stop. A good skin plan should eventually feel less like a battle and more like an understanding.

Depending on the cause, that may involve nothing more than a cleanser and moisturiser, or it may mean prescription acne treatment, microneedling, a professional facial, a skin booster or a conversation with your GP; occasionally it means putting the exfoliating toner back in the cupboard and giving your face a fortnight off. All of those can be good skincare decisions when they are made for the right reason. The important thing is understanding why that particular decision belongs to that particular skin.

ABOUT REBECCA BECKETT RN

Rebecca Beckett is a Registered Nurse and co-founder of No.1 Urban Aesthetics, a nurse-led aesthetics and professional skin clinic in Newcastle-under-Lyme, Staffordshire.

The clinic provides personalised Dermalogica PRO skin treatments, microneedling, skin boosters and aesthetic treatments, with care built around individual assessment rather than one-size-fits-all treatment packages.

No.1 Urban Aesthetics welcomes clients from Newcastle-under-Lyme, Stoke-on-Trent, Staffordshire, Cheshire and surrounding areas.

Not sure what your skin actually needs? A skin consultation is designed to identify the concern first and the treatment second.

CLINICAL SOURCES & READER NOTE

This feature has been informed by current UK guidance and peer-reviewed evidence, including NICE Guideline NG198, Acne vulgaris: management, last updated 30 April 2026; NHS guidance on contact dermatitis and changing moles; British Association of Dermatologists guidance on melasma and rosacea; DermNet clinical information on post-inflammatory hyperpigmentation; and recent systematic-review evidence examining microneedling for facial rejuvenation and acne scarring.

This article is for general education and does not diagnose a skin condition or replace individual medical advice. New, changing, persistent, severe or otherwise concerning skin symptoms should be assessed by an appropriate healthcare professional.

Illustrative photography is AI-generated and does not depict patients, clinical cases or treatment results. Author portrait and brand advertising imagery excepted.

clear start
by dermalogica

golden hour every hour

100%

agreed their **skin had an instant glow** after one application of the spf stick*

*based on consumer perception survey with 35 participants

shimmering + hydrating spf30 stick that won't clog pores