Guidelines given to doctors

about the diagnosis and treatment of vitiligo*

Giving diagnoses and prescribing treatments are clearly the responsibility of doctors. Patients cannot instruct their doctor to do anything, but it is useful for patients to know what doctors (and other medical professionals) are advised to do for patients with vitiligo. This eBooklet includes their guidance on:

- making a definite diagnosis,
- suggesting supportive treatments such as the use of camouflage,
- considering treatment options,
- offering psychological support.

Making a definite diagnosis

To start with, the diagnosis of vitiligo has to be confirmed. Diagnosis is more straightforward with the symmetrical type of vitiligo than with the less common segmental form (where patches are not the same on both sides of the body). If patients have irregular patterns of vitiligo, doctors are advised to refer patients for expert assessment by a dermatologist.

Three main skin conditions can be mistaken for vitiligo:

- **Tinea versicolor**, a superficial yeast infection that can cause loss of pigment on the upper trunk and chest.
- **Piebaldism**, a condition which also results in white patches of skin. There is also usually a forelock of white hair, which can be present at birth.
- **Idiopathic guttate hypomelanosis**, in which many small, white patches are found, mostly on the trunk or on sun-exposed parts of the limbs.

Initial Assessment

The doctor's examination should include looking at how the white patches are distributed, how big they are and whether depigmentation is total or partial. S/he will note whether the affected areas are symmetrical and whether they are around the nose and mouth etc.

With adults, the doctor may ask for a blood test to check if the **thyroid** is working properly. Vitiligo patients can be prone to thyroid conditions.

The doctor should also ask patients about the **effect of vitiligo** on their quality of life. You should not be offended if you are asked about how your skin condition is affecting your relationships and emotional wellbeing. Doctors are advised that, for some people, vitiligo can be devastating; it can have a significant impact on the patient's quality of life and self-esteem. It may cause social isolation and significant depression, create difficulties in sexual relationships, stigmatisation and affect perceived suitability for marriage.

It is suggested that patients are given information about the Vitiligo Society in the UK or other national patient help organisations.

Patients should also be offered advice about **sunscreens and cosmetic camouflage** including fake tanning products.

Deciding on appropriate treatment

Doctors are advised that, for adults and children with fair skin types it may be appropriate to consider not giving any treatments, except sunscreens and camouflage cosmetics. Obviously, this would be discussed with the patient.

Treatment of vitiligo can be viewed in two phases: the first is to halt the progression of the disease; the second is to encourage repigmentation. Some treatments can achieve both aims.

Guidance to doctors suggests that they should discuss treatment options with patients, bearing in mind that they are generally unsatisfactory. **Recent research indicates that the effectiveness of treatments depends not so much on a person's age but where the vitiligo is situated and**

when it started. It is most effective on treating the face, in childhood, in the early stages of the condition and when patches are small.**

Treatments available to non-specialists
(i.e. general practitioners)

Topical Steroids

The use of topical steroids is the usual first line treatment (creams that are used on the white patches). Recommended treatments for adults and children are slightly different.

For adults with recently developed vitiligo and for children, it is recommended that treatment with a potent (betamethasone valerate) or very potent (clobetasol propionate) topical steroid should be considered. These can repigment vitiligo, but only in a small proportion of cases. A trial period of no more than 2 months is advised because these creams can have side effects over a longer period.

Topical calcineurin inhibitors

Another type of cream, calcineurin inhibitors can also be prescribed. They have an advantage over steroids in that they do not thin the skin, which is a concern to many patients. In adults with symmetrical types of vitiligo, topical pimecrolimus should be considered as an alternative to a topical steroid. The side effects of topical pimecrolimus are better than that of a highly potent topical steroid, but stinging may occur sometimes.

In children, topical pimecrolimus or tacrolimus should be considered as an alternative to a highly potent topical steroid in view of their better safety profiles.

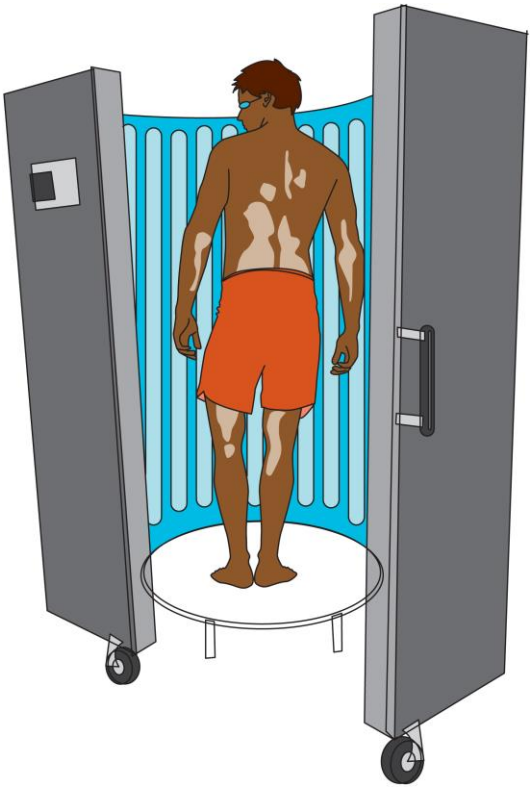
Doctors are advised that an **assessment** should be made after two months, to find out whether the patient's skin has responded to the above treatments.

Patients whose condition is difficult to diagnose, unresponsive to straightforward treatments, or is causing psychological distress, are usually referred to a dermatologist.

Guidance given on specialist treatments

Phototherapy

Phototherapy is appropriate for extensive vitiligo, especially if it is active. It has been a mainstay of treatment for several years. There is evidence that some vitiligo patients respond well to phototherapy with narrow band ultraviolet B (NB-UVB). Also, research indicates that NB-UVB is more effective than PUVA (psoralen in combination with UVA). Phototherapy treatments should be considered only in specialist dermatology units.



Depigmentation
(p- (benzyloxy) phenol (hydroquinone monobenzyl ether))

Where a patient has extensive vitiligo with a dark skin tone, especially on a cosmetically sensitive area such as the hands or face, it is worthwhile considering whether complete depigmentation of the affected areas might be beneficial. The profound effect that this may have culturally needs to be taken into account and fully understood by the patient. Depigmentation treatments should be reserved for severely affected adults and should be undertaken only by specialist dermatologists.

Surgery

Surgical treatment of vitiligo is appropriate for cosmetically sensitive sites, for example, on the face or back of the hands, but only if the condition has been inactive for 6-12 months. Surgical treatments are not recommended in children and should be considered only in specialist dermatology or plastic surgery units.

Systemic treatments

Since vitiligo is viewed as an autoimmune condition, it is natural to wonder whether systemic treatment might have something to offer. However, at present, the use of oral dexamethasone to arrest the progression of vitiligo cannot be recommended due to an unacceptable risk of side effects.

Psychological support

Doctors are advised to be aware that vitiligo can have profound psychological effects. When patients are severely affected by vitiligo, psychological support should be offered as a way of improving their ability to manage the condition. This support may be counselling or cognitive behavioural therapy. Parents of children with vitiligo should be offered psychological counselling, where needed.

* These guidelines are mainly a summary of the article *Vitiligo: concise evidence based guidelines on diagnosis and management* by David J. Gawkrodger, Antony D. Ormerod, Lindsay Shaw, et al, Postgrad Medical Journal 2010 86: 466-471.

** Information about this research, conducted in Japan, is taken from a poster presentation, *Evaluation of our recent therapies of vitiligo vulgaris by Shibata*, T. et al, at the 21st International Pigment Cell Conference, 20-24 Sept. 2011 Bordeaux, France.

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