

VITILIGO TREATMENT PROCEDURES
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In general, the treatment of Vitiligo remains unchanged, but there has been some fine tuning. It is now generally accepted that topical steroids help decrease the extension of Vitiligo and perhaps also with psoralens and light. But the steroids treatment is tricky. For a child under ten, one is probably better off using something very weak, perhaps the over-the-counter steroids of 0.5% hydrocortisone such as Lanacort or Cortaid. One does not want to get atrophy of the skins as occurs from long-term use of potent steroids. Between the ages of ten and twenty, one can use intermediate strength steroids, such as 1% hydrocortisone, or Westcort, with the addition of something potent, such as Diprolene or Temovate, once a week or once every other week. For adults, one could use something like Westcort or 1% hydrocortisone five days a week and potent steroids, such Diprolene or Temovate, two times a week. With regard to treatment with psoralens and sunlight or ultraviolet light, I believe that total body irradiation works better than treating only the white areas because there may be an immunosuppressive effect of total body irradiation that could be helpful.

There are nuances in the treatment of patients with Vitiligo that are not easy to list. Most important is the attitude of the physician toward the patient and to the treatment to be used. Whatever is done – repigmentation or depigmentation – one must realize that the process is long and demands a major commitment on the part of the patient. In addition to being upbeat, the physician has to be resourceful in changing therapy if the patient has stayed with a treatment for several months and nothing much has happened.

To begin with, one must take into account the age of the patient, the extent of the Vitiligo, and the presence of other disorders. The treatment for a child is going to be much different from that for an adult. If there is minimal depigmentation, the patient should be encouraged to go through with treatment. If the depigmentation is fairly extensive, one should tell the patient that there are three possibilities: one can undergo repigmentation, depigmentation, or have no treatment. Nearly all patients want repigmentation, but the possibility of depigmentation is mentioned early because if repigmentation does not work and the Vitiligo is extensive, they are aware of an alternative. If the patient does not want any treatment, keeping the skin as light as possible by avoiding exposure to sunlight usually keeps the contrast between pigmented and depigmented skin to a minimum.

In assessing a patient with Vitiligo for treatment with psoralens and light, one should keep in mind that if an associated illness, such as hyperthyroidism, pernicious anemia, or adrenal insufficiency is present, those disorders must be treated. If the metabolic disorder is satisfactorily treated, it does not mean the patient will get repigmentation, but that the pigment acquired over the summer months is more likely to be retained.

Adult patients must conscientiously take one to five tablets of trimethylpsoralen (5 mg) two hours before exposure to light three or four times a week. They should avoid getting a burn. Patients should not expect anything to happen in the first two months. Sometimes it takes three or four months for repigmentation to take off. If there is no response with trimethylpsoralen, 8-methoxypsoralen, with caution, should be tried. Side effects of treatment with psoralens are uncommon. We do not use as much energy from light for patients with Vitiligo as compared to those with psoriasis. There is usually more aging of the skin in patients with psoriasis than those with Vitiligo. Allergic reactions to psoralens are rare.

When a patient who has two or three months of treatment in the summer is seen in September or October states that the treatment does not work, the physician must look at the normal skin. If the normally pigmented areas are not particularly dark, it is safe to say that the patient did not have adequate treatment. If the patient's normal skin is very dark – darker than ever before -- one can say that the treatment is not working. When there is a great deal of repigmentation, the patient is a good candidate to continue treatment the following summer and probably during the winter. A loss of regained pigment during the winter months can usually be slowed or stopped by applying topical steroids.

Those who have tried PUVA without a success should, if they are adequately treated, quit.

If a patient does not want treatment, that is, either repigmentation or depigmentation, they can avoid being out in the sun and keep the skin as light as possible so that the Vitiligo is not so noticeable.

Depigmentation is still useful for many patients. That is usually done with 20% monobenzoether of hydroquinone applied to the skin once or twice daily for one to three years.

In the future, treatment for Vitiligo may involve immunosuppression and autologous pigment cell transplantation.