

# APPROACH TO TREATMENT OF PATIENTS WITH VITILIGO

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## GENERAL WORKUP

Patient history and complete skin examination  
Discussion about pathogenesis and treatment  
Ophthalmologic examination  
Laboratory test: CBC, RBC, indices FBS, TSH (radioimmunoassay) Bili, SGOT, alk phos, and ANA (PUVA only)  
Photographs (selected cases)  
Make patients aware of National Vitiligo Foundation and local chapter

## OPTIONS FOR TREATMENT:

SUNSCREEN: MAKEUP: DyODerm Vitadye (stains)  
Covermark, Dermablend  
REPIGMENTATION: Topical steroids  
PUVA: Topical, Oral-8-MOP (Indoor only) TMP (indoor or outdoor)  
8-MOP+TMP (indoor only)  
DEPIGMENTATION: hydroquinone (temporary and reversible)  
Monobenzylether of hydroquinone (permanent and irreversible)

FOLLOW-UP OBJECTIVES: Assess effectiveness of treatment  
Explore old and new options (such as tattooing, micrografting for PUVA refractory macules)

## VITILIGO REPIGMENTATION WITH PUVA

### PATIENT SELECTION:

OVER AGE 10  
PATIENT UNDERSTANDS COMMITMENT TO YEAR OF TREATMENT  
PATIENT UNDERSTANDS PUVA NOT A CURE  
VITILIGO IN NORMALLY PUVA RESPONSE AREAS  
OTHER REASONABLE TREATMENT OPTIONS INAPPROPRIATE OR INADEQUATE  
NORMAL PUVA EXCLUSIONS

VITILIGO REPIGMENTATION WITH INDOOR PUVA  
GENERAL APPROACH  
PSORALEN: 8MOP-ULTRA 0.3 mg/kg  
UVA:MPD (Vitiligo skin)

0.5-1.0 J INITIAL DOSE  
0.25-1.0 J INCREMENTS  
FREQUENCY: TWICE WEEKLY (not consecutive days)

## VITILIGO

### REPIGMENTATION WITH INDOOR PUVA

#### PSORALEN SELECTION

8-MOP ULTRA  
BEST SINGLE CHOICE - NO BIOAVAILABILITY VARIATION  
EFFICIENT  
LIMITED BY - GASTROINTESTINAL INTOLERANCE  
PHOTOTOXICITY  
8-MOP (crystalline)  
LESS GASTROINTESTINAL UPSET FOR SOME  
MORE POTENTIAL FOR BIOAVAILABILITY VARIATION THAN ULTRA  
TMP  
BEST SINGLE CHOICE FOR PATIENTS WHO COMBINE INDOOR AND OUTDOOR TREATMENTS WELL  
TOLERATED LIMITED BY - BIOAVAILABILITY  
VARIABLE ABSORPTION  
USUALLY LEAST PHOTOTOXIC OF AVAILABLE FORMULATIONS.

#### SPECIFIC VARIABLES

PSORALEN: 8-MOP (crystalline)  
8-MOP (liquid)  
TMP (crystalline)

UVA DOSE: Individualized  
TREATMENT FREQUENCY: Usually 2x a week (range 1-4x)  
TREATMENT DURATION: Months to years (continuous or interrupted) 25 to over 300 treatments.

I. INDUCTION PHASE  
INCREASE UVA UNTIL PHOTOTOXICITY REPIGMENTATION INITIATED  
PIGMENT DARKENING OF NORMAL SKIN.

#### PROBLEMS

8-MOP POORLY TOLERATED (NAUSEA, ETC.)  
Reduce 8-MOP dose by 10 mg.  
Switch to TMP 0.6 mg/kg  
NO RESPONSE  
Increase 8-MOP dose by 10 mg.  
Add TMP 10-20 mg  
Stop

MARKED PHOTOTOXICITY  
Reduce Joules, 8-MOP dose or Both  
Switch to TMP 0.6 mg/kg

II. SUSTAINING PHASE  
NO CHANGES USUALLY NECESSARY IF RATE OF RESPONSE IS ADEQUATE  
IF RESPONSE SLOWS OR BECOMES INADEQUATE REASSESS GOALS.

III. CONCLUDING PHASE  
PLAN TO STOP UPON ACHIEVING REASONABLE OBJECTIVES  
COMPLETE REPIGMENTATION OF EXPECTED RESPONSIVE MACULES  
Normally unresponsive areas (fingers, palms, etc.)  
Partially repigmented macules in repigmented areas.  
USUALLY REQUIRES COLLECTIVE REFOCUSING ON GOALS TO AVOID LONGTERM TREATMENTS

## VITILIGO REPIGMENTATION WITH OUTDOOR PUVA

SUNLIGHT EXPOSURE: Begin 5 to 10 minutes of midday sunlight per side

Increase by 3 to 5 minutes per side per treatment erythema or 45 minutes whichever comes first

Continue latter exposure time for duration of treatment season or until filled in

Twice weekly treatments usually adequate (not two days in a row)

RECORD KEEPING: Patients should keep written record of treatments and response

FOLLOW-UP: Patient should be seen by physician (dermatologist familiar with phototherapy at least every two months)

NOTE: Patient should avoid all sunlight except during the treatment on treatment days and use sunscreens on nontreatment days.

Indoor treatments off season may be required to sustain response of responding but incompletely repigmented macules.