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Clinical guidelines for Vitiligo in the Intermediate Dermatology Service

Therapeutic algorithm in children

Diagnosis and work-up

- Where Vitiligo is classical, the diagnosis is straightforward and can be made in primary care, but atypical presentations may require expert assessment by a dermatologist
- No work-up necessary unless indicated by clinical history or symptoms

No treatment option

- In children with skin types I and II during the consultation it is appropriate to consider, after discussion, whether the initial approach may be to use no active treatment other than use of camouflage cosmetics and sunscreens

Topical treatment

- Treatment with a potent or very potent topical steroid should be considered for a trial period of no more than 2 months
- Review after 1 month to assess response and detect any adverse effects (including telangiectasiae, skin atrophy, hypertrichosis, or striae). If there are any adverse effects or the response to treatment is already acceptable, consider discontinuing treatment
- After 2 months of corticosteroid treatment: If there is no response, discontinue treatment.
- If there is a partial response, continue treatment (possibly with an immediate break of 2 weeks, and further breaks after every 3 weeks of treatment). Monitor for adverse effects monthly
- If there is a complete response, stop the treatment
- Topical pimecrolimus or tacrolimus should be considered as second line alternatives to the use of topical steroids

Phototherapy

- Narrowband (NB) ultraviolet (UV) B phototherapy should be considered only in children who cannot be adequately managed with more conservative treatments, who have widespread Vitiligo, or have localized Vitiligo associated with a significant impact on patient's quality of life (QoL)

- Ideally, this treatment should be reserved for patients with darker skin types
- NB-UVB should be used in preference to PUVA in view of evidence of greater efficacy, safety and lack of clinical trials of PUVA in children

Systemic treatments

- The use of oral dexamethasone to arrest progression of Vitiligo cannot be recommended due to an unacceptable risk of side effects

Psychological treatments

- Clinicians should make an assessment of the psychological and QoL effects of Vitiligo on children
- Psychological interventions should be offered as a way of improving coping mechanisms
- Parents of children with Vitiligo should be offered psychological counselling

Therapeutic algorithm in adults

Diagnosis and work up

- Where Vitiligo is classical, the diagnosis is straightforward and can be made in primary care but atypical presentations may require expert assessment by a dermatologist
- For adults with non-segmental Vitiligo, check for other autoimmune diseases. There is no need to do this in people who have segmental Vitiligo unless there are other indications
- Enquire about symptoms of hyperthyroidism, hypothyroidism, diabetes mellitus, pernicious anaemia, and Addison's disease
- In view of the high prevalence of autoimmune thyroid disease in patients with vitiligo take a blood sample to check thyroid function and for thyroid autoantibodies. Monitor thyroid function annually thereafter
- Advise the person to report any unusual symptoms (for example those of hyperthyroidism and hypothyroidism, diabetes mellitus, pernicious anaemia, and Addison's disease)

No treatment option

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- In adults with skin types I and II it is appropriate to consider, after discussion, whether the initial approach may be to use no active treatment other than use of camouflage cosmetics and sunscreens

Topical treatment

- In adults with recent onset of Vitiligo, treatment with a potent or very potent topical steroid should be considered for a trial period of no more than 2 months
- Topical pimecrolimus or tacrolimus should be considered as second line alternatives to topical steroids

Phototherapy

- NB-UVB phototherapy (or PUVA) should be considered for treatment of Vitiligo only in adults who cannot be adequately managed with more conservative treatments, who have widespread Vitiligo, or have localized Vitiligo with a significant impact on QoL
- Ideally, this treatment should be reserved for patients with darker skin types
- NB-UVB should be used in preference to oral PUVA in view of evidence of greater efficacy

Systemic therapy

- The use of oral dexamethasone to arrest progression of Vitiligo cannot be recommended due to an unacceptable risk of side effects

Psychological treatments

- Clinicians should make an assessment of the psychological and QoL effects of Vitiligo on patients
- Psychological interventions should be offered as a way of improving coping mechanisms in adults with Vitiligo

1. Guidelines for the management and diagnosis of vitiligo. Gawkrodger DJ, Ormerod AD, Shaw L, Mauri-Sole I, Whitton ME, Watts MJ, Anstey AV, Ingham J, Young K. Br J Dermatol 2008; 159; 1051-1076.
2. Guidelines for the management of vitiligo: the European Dermatology Forum consensus .Taieb1, A. Alomar2, M. Böhm3, et al. British J Dermatology ;168, Issue 1, pages 5–19, January 2013