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COMMENTARY

Global recommendations for vitiligo management

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Over decades, dealing with vitiligo needed a high degree of frustration tolerance for both patients and doctors. Overall knowledge was limited, and the degree of suffering of patients affected was not really appreciated by society nor even in the dermatological community. Often treatment was started late—if it all. There were few effective concepts for management. Who wanted to achieve something needed a long-term strategy for the different treatment goals namely stabilization, re-pigmentation or finally de-pigmentation. The last international (European) guidelines on vitiligo date back to 2013.[1]

It is therefore to be welcomed that an international expert group consisting of 42 experts and 4 patient representatives from all over the world gathering as 'international vitiligo task force' in several online and physical meetings was able to produce global recommendations for diagnosis and management of vitiligo.[2,3]

These experts found together across five continents some of them via existing expert groups like the East Asian Vitiligo Association (EAVA), the Global Vitiligo Foundation (GVF), the Vitiligo European Task Force (VETF), the Vitiligo International Patient Organisation Committee (VIPOC) building the Vitiligo Task Force (VTF). They were able to summarize evidence-based and expert-based recommendations at an S1 level—although not in the strict methodology of a systematic review—intended for use in daily clinical routine. In the final meetings, a total of 18 patient representatives participated in the development of these recommendations; this is especially noteworthy with regard to the important aspect of 'shared decision making'.

In this first theme issue on vitiligo, two parts of these global recommendations are published, part 1 focusing on newly designed algorithms for vitiligo management[2] whereas in part 2 individual treatment modalities are discussed in depth.[3]

In the first part, a consensus on nomenclature/terminology has been achieved with vitiligo (non-segmental), segmental vitiligo, focal vitiligo and undetermined/unclassified forms.

The experts recommend an intense initial patient assessment with use of available and reproducible scoring systems to assess not only the diagnosis but also the severity and the disease activity. The quality of life should always be included.[4]

Before deciding about treatment, patients have to be informed about the disease and possible interventions and the treatment goals have to be fixed according to patients expectations with shared decision making. There is consensus that early intervention is crucial in preparing the way for successful management.[5]

The group proposes algorithms for non-segmental and segmental vitiligo with regard to stabilization, re-pigmentation, or in the most severe generalized vitiligo, de-pigmentation of the remaining unaffected skin.

In the part 2, specific treatment options are discussed in depth.[3] The group agrees that unfortunately many vitiligo patients are considerably undertreated. Parameters for selection of treatment modality should be the activity, the extent and the location of vitiligo lesions.

Among the different treatment options, first topical steroids are mentioned, also with consideration of the side effects.

Topical calcium inhibitors are quite effective, but still off label in most countries.

The recently registered topical Janus kinase (JAK) inhibitors like ruxolitinib have shown remarkable efficacy in clinical trials.[6]

UV phototherapy still remains actual whereby narrow band UVB seems to be the preferred to topical PUVA or

Linked articles: Nanja van Geel et al. J Eur Acad Dermatol Venereol 2023; 37:2173–2184. https://doi.org/10.1111/jdv.19451 and Julien Seneschal et al. J Eur Acad Dermatol Venereol 2023; 37:2185-2195 https://doi.org/10.1111/jdv.19450.

excimer devices. UV therapy also can be performed by the patient at home with handheld devices for localized skin areas.[7]

Among systemic treatments, oral steroids in the form of minipulse treatment as well as immunosuppressives like methotrexate, ciclosporin, azathioprine and minocycline are discussed, with mentioning the lack of studies of robust methodology for most of these substances or combinations. There is at the moment no biologic to be recommended for vitiligo.[8]

An interesting option is the addition to phototherapy is the use of a systemic antioxidant like Polypodium leukotomos or gliadin-protective superoxide dismutase (SOD).[9]

Surgical procedures remain an option for stable vitiligo in localized or segmental forms.

De-pigmentation strategies have to be discussed with the patient in the light of socio-cultural issues and long-lasting side effects.[10]

The group also discusses a variety of new emergent therapies actually in the 'pipeline' in clinical trials.

The authors reached consensus that therapeutic management of vitiligo often starts too late, and that early and aggressive treatment is a way to improve prognosis. New therapeutic options such as JAK inhibitors show exiting developments for the future.

CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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