doi:10.36849/JDD.7572e

The Pediatric Dermatologist's View of Pediatric Vitiligo

Mark Weingarten MD,[a] Michelle Schwartz MD,[b] Candrice Heath, MD,[c] Nanette B. Silverberg MD[a]

[a]The Department of Dermatology, Mount Sinai Medical Center, New York, NY
[b]The Department of Dermatology, SUNY Downstate Medical Center, Brooklyn, NY
[c]The Department of Dermatology, Lewis Katz School of Medicine at Temple University, Philadelphia, PA

ABSTRACT

Background: No guidelines exist for pediatric vitiligo.
Objective: To identify practice patterns of pediatric dermatologists treating vitiligo.
Methods: A PeDRA survey was completed online by 56 pediatric dermatologists.
Results: Practitioners reported feeling most comfortable treating 13 to 17 years old and least comfortable treating infants. Quality of life was assessed by interview in 89.3%. Topical calcineurin inhibitors (TCI), topical corticosteroids (TCS), Narrowband UVB, coverup makeup, topical JAK inhibitors (tJAKi), and 308-nm laser were the leading vitiligo therapeutics chosen. 94.5% of practitioners reported experiencing frustration due to difficulties procuring therapies.
Conclusions: Pediatric vitiligo has notable effects on quality of life. Some therapeutic options exist which are preferred by pediatric dermatologists. There is a need for more data on therapeutics in infants and young children,

J Drugs Dermatol. 2024;23(2):e77-78. doi:10.36849/JDD.7572e

To The Editor,

Few Surveyed practitioners provide medical intervention for vitiligo in the Netherlands.[1] In a recent United Kingdom qualitative patient survey, patients reported that their physicians had low awareness of the disease and available treatments, dismissing the disease as cosmetic.[2] There is evidence that in Saudi Arabia and India, there is a greater focus on therapy.[3,4] Little is known about pediatric dermatology practitioner attitudes and management of vitiligo.

A survey was designed by the Pediatric Dermatology Research Alliance (PeDRA) Skin of Color Focus Group investigators, reviewed by the PeDRA surveys committee, and received an exemption from the Mount Sinai Health Systems IRB.

Fifty-six of one hundred and seven eligible pediatric dermatologists completed the survey. Forty-four had been in practice for more than 5 years. Practitioners reported seeing an average of 8 pediatric and adolescent patients with vitiligo per month. The majority practiced in the US (n=45, 80.4%) and Mexico (n=6, 10.7%) and 48 were board-certified pediatric dermatologists; Providers surveyed reported feeling most comfortable treating older patients 13-17 (n=48, 85.7%), 5-8 (n=40, 71.4%), 2-4 years of age (n=18, 32.1%), less comfortable with toddlers and infants 13-23 (n=12, 21.4%), 7-12 (n=4, 7.1%), and 0-6 months (n=1, 1.7%) respectively. Quality of life (QoL) was assessed by interview (n=50, 89.3%), psychiatric screening (n=14, 25%), and QoL scores (n=11, 19.6%). Bloodwork was performed infrequently with full thyroid panels (n=38, 67.8%) and 25-OH vitamin D levels (n=27, 48.2%) being the most common labs (Table 1).

TABLE 1.

Demographics of Respondents with Alopecia Areata	
Geographic Location	**n (%)**
United States	45 (80.4%)
Mexico	6 (10.7%)
Chile	1 (1.8%)
Costa Rica	1 (1.8%)
France	1 (1.8%)
Spain	1 (1.8%)
South Korea	1 (1.8%)
Bloodwork Performed	**n (%)**
Always Performed	13 (23.3%)
Usually Performed	12 (22.6%)
Sometimes Performed	11 (19.6%)
Rarely Performed	9 (16.1%)
Full Thyroid Panel	38 (67.8%)
25-OH Vitamin D	27 (48.2%)
Celiac	11 (19.6%)
Rheumatoid Factor	8 (14.3%)
Vitamin B12	8 (14.3%)
Zinc	5 (8.9%)
Copper	4 (7.1%)

Indicators of rapid color loss were thought to be ongoing color loss (n=49, 88%), acral location (n=33, 58.9%), greater than 25% depigmentation (n=32, 57.1%), and lesional poliosis (n=29, 51.7%). Greater than 50% color-loss (n=54, 96.4%), acral location (n=47, 83.9%), and prolonged disease course (n=42, 75%) were

doi:10.36849/JDD.7572e

TABLE 2.

Therapeutic Choices for Pediatric Alopecia Areata							
	<8-year-old with facial depigmentation <25% without eyelid localization	< 8-year-old with facial depigmentation <25% with eyelid localization	<8 years old with > or =25% depigmentation without eyelids	> 8-year-old with <25% BSA generalized depigmentation (trunk and extremities)	> 8-year-old with >25% BSA generalized depigmentation (trunk and extremities)	Segmental vitiligo localized to face	Segmental vitiligo localized to body
Topical calcineurin inhibitors	46 (82%)	52 (92.9%)	47 (81%)	29 (51.8%)	22 (39.3%)	46 (82.1%)	24 (42.9%)
Topical corticosteroids	29 (51.8%)	17 (30.3%)	30 (51.7%)	49 (87.5%)	39 (69.6%)	--	--
Class 1	5 (8.9%)	5 (8.9%)	5 (8.6%)	24 (42.8%)	16 (28.6%)	--	25 (44.6%)
Class 2	6 (10.7%)	2 (3.4%)	6 (10.3%)	12 (21.4%)	11 (19.6%)	--	10 (17.6%)
Class 3	9 (16.1%)	4 (6.8%)	9 (16.7%)	8 (14.2%)	7 (11.9%)	--	9 (16.1%)
Class 4	3 (5.3%)	4 (6.8%)	3 (5.2%)	5 (8.9%)	5 (8.5%)	--	4 (7.1%)
Class 5	6 (10.7%)	2 (3.4%)	5 (8.6%)	0 (0.0%)	0 (0.0%)	--	--
Narrowband UVB	5 (8.9%)	7 (11.9%)	7 (12.1%)	17 (30.4%)	31 (55.4%)	--	15 (26.8%)
Topical Jak inhibitors	5 (8.9%)	5 (8.9%)	6 (10.3%)	0 (0.0%)	5 (8.9%)	8 (14.3%)	5 (8.9%)
Coverup makeup	6 (10.7%)	8 (14.2%)	8 (13.8%)	0 (0.0%)	0 (0.0%)	--	--
Excimer laser	9 (16.1%)	5 (8.9%)	11 (19%)	8 (14.2%)	5 (8.9%)	14 (25%)	--
Oral Steroids	1 (1.8%)	0 (0.0%)	2 (3.4%)	0 (0.0%)	10 (17.9%)	--	--
Home Phototherapy	0 (0.0%)	0 (0.0%)	3 (5.2%)	5 (8.9%)	8 (14.3%)	--	--
Topical PUVA	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (3.4%)	2 (3.4%)	--	--

poor prognostic indicators in the opinion of survey participants. Topical calcineurin inhibitors (TCI), topical corticosteroids (TCS), Narrowband UVB, coverup makeup, topical JAK inhibitors (tJAKi), and 308-nm laser were the leading vitiligo therapeutics chosen (Table 2). Clinical photographs, measurement of lesion size (n=48 each, 85.7%), subjective patient-reported satisfaction (n=41, 73.2%), and percent re-pigmentation (n=34, 60.7%) were used most for disease monitoring. VASI scores (n=3, 5.3%), BSA (n=3, 5.3% and mobile device apps (n=1, 1.8%) were uncommonly used. Practitioners almost universally reported occasional to constant frustration in the care for pediatric vitiligo due to a lack of treatment options and insurance barriers (94.5%). Most (77.2%) reported always or often experiencing challenges in procuring appropriate therapies. Parental phobia of topical corticosteroid use in pediatric patients was noted to occur occasionally (n=29, 51.8%) to frequently (n=10, 17.8%).

TCI and TCS were favored for non-segmental and segmental vitiligo, with NB-UVB, excimer laser, tJAKi, and cosmetic cover-up being used consistently, but less frequently. Systemic agent usage was very limited. Barriers to the therapy of vitiligo identified by pediatric dermatologists include poor access to therapeutics, reduced comfort in treating children under 2 years of age, and parental anxiety. The publication of long-term safety data and an authoritative guideline to streamline diagnosis and treatment are warranted.

DISCLOSURES

Nanette Silverberg, MD has been a speaker and advisor for Astellas, and Incyte. Dr Schwartz and Mr Weingarten both report no conflicts of interest.

IRB: Pediatric Dermatology Research Alliance Approved IRB.

REFERENCES

1. Njoo MD, Bossuyt PM, Westerhof W. Management of vitiligo. Results of a questionnaire among dermatologists in The Netherlands. *Int J Dermatol.* 1999;38(11):866-872. doi:10.1046/j.1365-4362.1999.00822.x
2. Teasdale E, Muller I, Abdullah Sani A, et al. Views and experiences of seeking information and help for vitiligo: a qualitative study of written accounts. *BMJ Open.* 2018;8(1):e018652. doi:10.1136/bmjopen-2017-018652
3. Ismail SA, Sayed DS, Abdelghani LN. Vitiligo management strategy in Jeddah, Saudi Arabia as reported by dermatologists and experienced by patients. *J Dermatolog Treat.* 2014;25(3):205-211. doi:10.3109/09546634.2012.762638
4. Chatterjee M, Das A. Management of vitiligo amidst the COVID-19 pandemic: a survey and resulting consensus. *Indian J Dermatol.* 2021;66(5):479-483. doi:10.4103/ijd.ijd_859_20

AUTHOR CORRESPONDENCE

Nanette Silverberg MD

E-mail:..... Nanette.silverberg@mountsinai.or