Transcript Details
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Active Vitiligo: What to Look For

Neal Bhatia, MD:
Hi, I am Dr. Neal Bhatia. I'm Chief Medical Editor of Practical Dermatology, and I'm here with my friend John Harris. I call him Mr. Vitiligo because he set the bar high for how we learn about vitiligo. John, you gave a lecture at a couple of different meetings. Tell us what's going on with vitiligo as far as defining active vitiligo. What does that mean to a dermatologist?

John E. Harris, MD, PhD:
So first of all, it's real exciting time for vitiligo. So much is happening and coming. I would say that one of the most important things for a clinician is to be able to recognize when their patient has stable versus active disease. If it's active, it can spread very quickly and it can go to areas that are irreversible. So that's really an emergent time. And so being able to recognize active vitiligo allows you to shut that off pretty quickly. You can ask your patients if they've had a spot in the last few months. That's one way to do it. But you can also look for three clinical signs in the clinic and if you see those things, it means it's active. Confetti vitiligo, tiny macules of depigmentation. Trichrome vitiligo, koebnerization or inflammatory vitiligo. Those are all clinical signs that tell you it's active. It needs to be shut off quickly. And we use oral pulse steroids to do that.

Neal Bhatia, MD:
It tells us a lot too about definitions. Those of us who do the trials, we do the VASI score, we make the thumb prints, make the surface area. Is that something dermatologists should be doing in the clinic?

John E. Harris, MD, PhD:
Yeah, it's not as critical. I mean, I would say if the body surface area is over 5%, it's pretty hard to expect your patients to use topicals only. So that's kind of what I'm always thinking about. Well, is it 5%? Is it 10%? Is it more for those purposes? I don't think precise VASI measuring is really critical in the clinic.

Neal Bhatia, MD:
What's in the pipeline and what's the regimen of choice today?

John E. Harris, MD, PhD:
Yeah, so we're super excited about the FDA approval. First FDA-approved drug to reverse vitiligo a year and a half ago. It's topical ruxolitinib. So we're using that a lot. Doesn't have the side effects of steroids, so patients can use it anywhere and they don't need a break from it and has strong efficacy. So we're pretty excited about that.

Neal Bhatia, MD:
The PK data shows that the black warning is not even merit so that's good.

John E. Harris, MD, PhD:
Yeah, it's similar to tacrolimus. We struggled with that black box for so long. So we try to explain to patients why the black box is there. It's really all based on what the oral drug does and that we don't absorb anywhere near that dose through the skin.

Neal Bhatia, MD:
Where do we draw the line with topicals to systemic? What surface area is the number we should think about?

John E. Harris, MD, PhD:
The approved body surface area for topical ruxolitinib is 10%. It can only be used on 10% of the body surface area. I think it's hard to use more than 5%. And so patients, you know, it's up to them. But if they have more than 10% body surface area, they can use it on

10% but it's still a lot to expect.

Neal Bhatia, MD:
It's a lot. Yeah. I mean, it's not like they're treating a rash. A lot of people like to go top down, but when it's that much surface area, you're really thinking about working from inside out.

John E. Harris, MD, PhD:
We ask the patient to prioritize areas of their body, so they probably want to use it on their face. They might want to use hands and forearms. If they have more, then they focus on the areas that matter most. A lot of dermatologists tell patients that the sun is terrible for their vitiligo. And then they're all confused when they come in and I say, "Well, we've been using the sun since the Iron Age to treat vitiligo", so the sun actually helps vitiligo. I have patients who come from all over the world. Some of them come from tropical areas and they don't have access to narrowband so we use the sun.

Neal Bhatia, MD:
Right.

John E. Harris, MD, PhD:
If you're on narrowband UVB, then you got to protect yourself from the sun because if you add the sun on top of that, then you'll burn.

Neal Bhatia, MD:
Yeah.

John E. Harris, MD, PhD:
And so it just kind of depends. We really tailor everything based on what the patient can do.

Neal Bhatia, MD:
Exactly. And I'm sure we take into account Fitzpatrick type and everything else.

John E. Harris, MD, PhD:
That's right.

Neal Bhatia, MD:
But it is a bit of a double-edged sword to say, "Okay, well, protect yourself from the sun, but we also need it for the treatment." Well, John, thank you. This was a great overview of vitiligo and we'll see you next time. Thank you.

John E. Harris, MD, PhD:
Thanks.