Successful Treatment of Vitiligo With 0.1% Tacrolimus Ointment

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REPORT OF CASES

CASE 1
A 23-year-old Hispanic woman with Fitzpatrick type IV skin presented with vitiligo vulgaris affecting 75% of her face, including complete depigmentation of the eyelids, chin, cheeks, and perioral skin. This had developed progressively over a 2-year period. As is the standard practice of our vitiligo clinic, thyroid function testing, blood cell counts, and vitamin B12 levels were taken; all were within normal limits. Mometasone furoate ointment was applied twice daily for 3 months with no signs of follicular repigmentation either on visual examination or with the use of the Wood light.

CASE 2
A 24-year-old man with Fitzpatrick type II skin presented with a history of vitiligo vulgaris for 12 years. At the time of presentation, he had depigmentation of 60% of his body surface area, including the eyelids, chin, axillae, elbows, hips, knees, and back. Thyroid function findings, blood cell counts, and vitamin B12 levels were all within normal limits. Topical mometasone furoate cream was applied twice daily for 4 months, during which the patient also underwent a course of narrowband UV-B irradiation to the entire body. Despite these therapies, no repigmentation occurred, even under Wood light examination. We believe this was owing to the use of protective eyewear in the phototherapy booth.

CASE 3
A 10-year-old African American boy with Fitzpatrick type VI skin had a history of microcephaly, absence of the radii bilaterally, and learning disabilities. Eight months prior to presentation, he began to develop rapid depigmentation of the forehead, forearms, chest, back, and calves. Thyroid function findings, blood cell counts, and vitamin B12 levels were all within normal limits. Triamcinolone acetonide ointment (0.1%) was tried for 3 months with no repigmentation.

SOLUTION
A trial of topical 0.1% tacrolimus ointment was begun for the face and eyelids in each of these patients. Patients were instructed to apply the medication to the affected areas twice daily on dry skin. Patients were allowed unprotected (no sunscreen) natural sunlight exposure at midday: 5 minutes in the summer and 10 minutes in fall, winter, and spring. They were instructed to apply sunscreens of sun protection factor 30 or higher at all other times. The patient in case 1 developed noticeable follicular repigmentation after 3 weeks of therapy and had complete repigmentation in 4 months (Figure 1). Patient 2 (Figure 2) began to show repigmentation at 6 weeks. He was completely repigmented in 2 months, at which time he showed no Wood light enhancement. His repigmentation persisted 9 months later. Patient 3 demonstrated good facial repigmentation in 4 weeks and complete repigmentation in 2 months. All 3 patients have maintained repigmentation after 6 to 9 months of follow-up, even with discontinuation of treatment. None of the patients had any local adverse effects, including pruritus or erythema.
Vitiligo is an acquired, idiopathic disorder characterized by depigmented macules that result from damage to and destruction of melanocytes. Although the disease can occur at any age, 50% of patients acquire it before age 20 years.1 Two of the major theories of the pathogenesis of vitiligo are the autoimmune theory and the autocytophagy theory.1,2 The autoimmune theory postulates that patients with vitiligo form autoantibodies against melanocytes. The existence of antimelanocyte surface antigen antibodies has been demonstrated, and the severity of vitiligo has proven to be related to the amount of antibodies present.2 Vitiligo has been associated with antibody-mediated autoimmune diseases such as thyroid disease, pernicious anemia, diabetes mellitus, Addison disease, alopecia areata, and myasthenia gravis.3

The autocytophagy theory postulates that melanocytes are destroyed either by themselves through self-generation of melanin precursors (or metabolites) or by keratinocytes, which release chemicals that generate oxidative stresses. It is believed that the normal defense mechanisms of melanocytes against oxidative stress and melanin precursors are defective in vitiligo melanocytes.1

Patients have numerous treatment options available, but none is universally effective. Even among patients who respond to treatment there is a high potential for relapse.3 For this reason, most clinicians surveyed do not offer therapy to their patients with vitiligo.4 However, the disease is cosmetically disfiguring and may produce profound adverse psychological effects because it can lower self-esteem and interfere with interpersonal relationships. Support groups and other adjuncts to therapy may be very beneficial and should always be offered to the patient.5

Systemic and topical psoralens with subsequent long-wave UV-A exposure (PUVA) is the most common treatment prescribed.1 Narrowband UV-B irradiation has also demonstrated some success in treating vitiligo.3 Surgical procedures are performed for patients who have not responded well or completely to medical treatments, whose disease is stable, and whose vitiligo is segmental or localized.2 Grafts of autologous epidermal sheets or cultured melanocytes can be surgically placed into areas where PUVA has produced incomplete repigmentation.1,6

Patients with extensive vitiligo vulgaris receive the most benefit from PUVA. Several clinical studies have shown successful repigmentation after long-term PUVA therapy. Despite long-term use of PUVA, the success rate in many studies is only slightly greater than 50%.5,7,8 Furthermore, eyelids cannot be treated because of the need to wear protective eyewear under UV-A irradiation. Up to 75% of PUVA-treated patients may relapse within 1 to 2 years, according to Shaffrali et al.1 The short-term adverse effects of PUVA include pruritus, erythema, hyperpigmentation, hypertrichosis, xerosis, nausea, and
Vitiligo can be devastating for patients and at times, very difficult to treat. As the authors note, corticosteroids and phototherapy have been our mainstays of treatment. Surgical approaches to the disease are less commonly used in the United States than are these other modalities.

The authors describe 3 patients who responded well to therapy with topical tacrolimus. The presumed mechanism of action relates to the drug’s immunosuppressant effects. The therapy was well tolerated in their patients. Most of the adverse effects experienced to date when treating atopic dermatitis relate to skin irritation, burning sensation and pruritus, and folliculitis. No significant blood levels have been detected, even when applying the drug to large surface areas, with the exception of children with Netherton syndrome, as reported by Allen et al in the Archives. In addition, the drug has not been found to be phototoxic, photoallergenic, or photosensitizing, which is important when treating depigmented skin. The relatively quick response and lack of adverse effects make this an exciting new option for patients with vitiligo.

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References

Clinicians, local and regional societies, residents, and fellows are invited to submit cases of challenges in management and therapeutics to this section. Cases should follow the established pattern. Submit 4 double-spaced copies of the manuscript with right margins nonjustified and 4 sets of the illustrations. Photomicrographs and illustrations must be clear and submitted as positive color transparencies (35-mm slides) or black-and-white prints. Do not submit color prints unless accompanied by original transparencies. Material should be accompanied by the required copyright transfer statement, as noted in “Instructions for Authors.” Material for this section should be submitted to George J. Hruza, MD, Laser and Dermatologic Surgery Center Inc, 14377 Woodlake Dr, Suite 111, St Louis, MO 63017.