Oral Minipulse Therapy in Vitiligo

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Though various modalities of treatments are available for vitiligo, none is uniformly effective. Systemic corticosteroids have been used in the treatment of vitiligo presuming it to be autoimmune in nature [1]. In order to reduce the side-effects, it can be administered in ‘pulse’ form with beneficial effects [2]. ‘Oral minipulse’ (OMP) therapy implies use of cyclical pulse dose corticosteroids in much smaller doses compared to the usual pulse therapy. Therefore, the side-effects are further minimized, and this therapy can be used by patients at home with regular follow-up at the clinic [3]. Recently Pasricha and Khaitan [4] tried corticosteroid OMP therapy in 40 vitiligo patients with encouraging results. We report herein our results with OMP in vitiligo.

Thirty-seven patients (23 male, 14 female) with rapidly spreading vitiligo covering more than 2% body surface area were recruited. Their ages ranged from 6 to 46 years (mean 22.62 years), and the duration of disease varied from 1.5 months to 5 years (mean 1.81 years). Of 37 patients, 31 (83.8%) had vitiligo vulgaris, while 6 (16.2%) had segmental vitiligo.

All patients were screened for any contraindication for systemic corticosteroids. A single dose of OMP in adults consisted of 10 tablets of dexamethasone (0.5 mg each) given on 2 consecutive days in a week after breakfast in the morning. In children (< 16 years old) the dose was halved. A minimum of 5 doses and a maximum of 25 doses were tried. No other treatment was prescribed during the study period. The therapeutic response was graded as no response, weak, moderate, excellent response and total clearance. Patients were reviewed every 5 weeks by the senior author. Thirty-two (86.4%) patients completed the trial, while 5 (13.6%) defaulted. In 14 (43.8%) patients, new lesions stopped appearing and there was mild to moderate repigmentation, while in 18 (56.2%) there was no response (table 1). Patients who showed a response mostly showed repigmentation within the first 15 weeks (doses) of treatment. Patients with segmental vitiligo were worst

Table 1
Therapeutic response of vitiligo to OMP therapy

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Patients</th>
</tr>
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<tbody>
<tr>
<td>No response</td>
<td>5</td>
</tr>
<tr>
<td>Weak</td>
<td>18</td>
</tr>
<tr>
<td>Moderate</td>
<td>14</td>
</tr>
<tr>
<td>Excellent</td>
<td>0</td>
</tr>
<tr>
<td>Total clearance</td>
<td>0</td>
</tr>
</tbody>
</table>
Figures in parentheses show numbers of children who completed the study. One dose of OMP: 5 and 2.5 mg dexamethasone orally/day for 2 consecutive days in a week in adults and children, respectively.

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responders. Only 1 (16.6%) of 6 cases showed mild repigmentation. Of 12 children included in this trial, 3 defaulted. Four children out of 9 who completed the trial had mild to moderate response after 14-16 doses of OMP. This response is similar to that seen in adults. No side-effects pertaining to OMP treatment were observed.

Thus, our experience with OMP therapy is not as encouraging as reported by Pasricha and Khaitan [4], where they observed a halt in disease progression in almost 90% of patients. Only 14 (43.8%) subjects in our study showed a mild to moderate response to the scheduled regimen. Variation of OMP doses was not attempted in our study. We feel that the response in patients with extensive vitiligo would perhaps be still lower. None of the patients complained of any side-effects due to corticosteroids while on OMP therapy or during the follow-up period as observed by Pasricha and Khaitan [4]. Thus, OMP seems to be a relatively safe modality of treatment, especially in rapidly spreading vitiligo, though its efficacy is not very high. It is also concluded from the present study that if response does not start within the initial 15 weeks (doses), chances of treatment failure are high. Once repigmentation appears, other modalities may be initiated to sustain it. OMP therapy might also be useful in those vitiligo patients who develop new lesions on starting PUVASOL therapy, i.e. intake of oral psoral-ens followed by graded sun exposure.

References
Dermatology 1995; 190:252
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‘Hanging Curtain’ Sign in Pityriasis rosea

A few fascinating signs characterize different dermatologic disorders, i.e. the capet tack sign in discoid lupus erythematosus, the dimple sign in dermatofibroma and the ‘nose
A collarette of scales attached at the margin with a clear centre characterizes a typical medallion lesion of PR [2] (fig. 1). When the skin is stretched across the long axis of a medallion lesion of PR, the scales being finer, lighter and attached at one end tend to fold across the line of stretch (fig. 2). This gives the appearance of a hanging curtain which is also attached at one end (hanging string) and hangs with multiple folds along its long axis, gravitational force being the stretch factor.

The diagnosis of PR tends to be missed when only the herald patch is present, when lesions are few or the peripheral collarette of scales is not clearly distinguishable. In such circumstances this sign helps to diagnose PR and sufficiently excludes other closely similar conditions.

References

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