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Targeted phototherapy with excimer light is not efficacious in the management of residual vitiligo patches following whole-body narrowband ultraviolet B light therapy: Results of a retrospective case series

Sir,

Complete repigmentation in vitiligo is difficult to achieve even after adequate whole-body narrowband ultraviolet B light therapy. We undertook a retrospective review of the efficacy of excimer light in producing repigmentation in residual vitiligo patches in non-segmental stable vitiligo (body surface area <5%) patients who had received at least 50 sessions of narrowband ultraviolet B. A total of fifteen cases received excimer light, of which two cases were excluded as they had received less than ten sessions. Thirteen cases with a mean age 25.9 years were included [Table 1]. Seven patients had vitiligo vulgaris while six patients, acrofacial vitiligo. The mean number of narrowband ultraviolet B sessions received before excimer light therapy was 148.8 ± 92.2 (range = 53–310). Besides narrowband ultraviolet B, 12 patients had concomitantly received topical therapy (tacrolimus 0.1% ointment and fluocinolone acetonide 0.1% cream) which was continued during excimer light therapy. The excimer light was given using handheld xenon chloride lamp (Exciplex®, Clarteis, Valbonne, France) two–three times per week on non-consecutive days. It was initiated at a prefixed dose depending on the site of irradiation [Table 1]. The same dose was repeated if erythema persisted at 48 h, while if symptomatic erythema and/or blisters occurred, excimer therapy was omitted and the dose was reduced by 50 mJ in the subsequent session. Patients were advised adequate photoprotection after excimer light therapy. Patients with lesions on or lesions limited to hands, feet, elbows and knees were excluded from the study. The mean number of sessions received was 21.4 ± 8.3. The median dose of excimer therapy delivered was least for head and neck followed by trunk, upper limbs and lower limbs [Table 1]. Efficacy was measured as patient and investigator global assessment (photographic review), in terms of percentage improvement from baseline.

On patient global assessment, median improvement of 10% (range – 5–25%) was appreciated by four (30.7%) patients.

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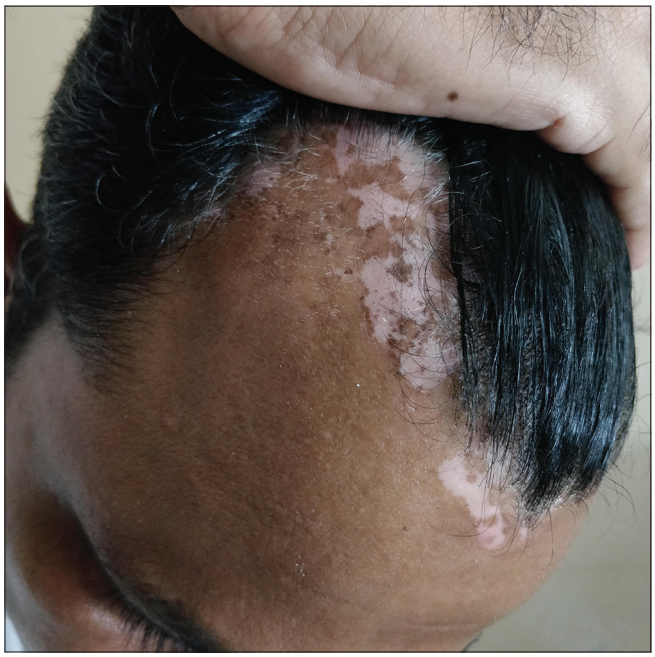

Figure 1a: Depigmented patches of vitiligo over face at baseline

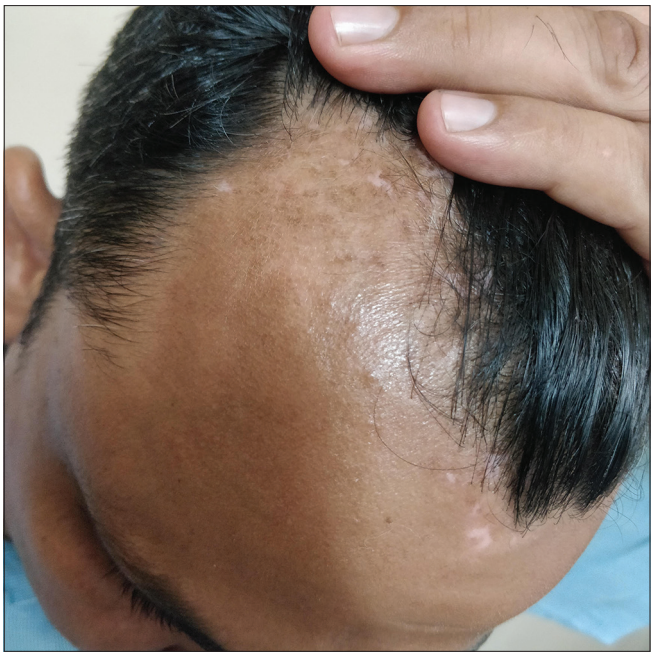

Figure 1b: More than 80% repigmentation in patches after 25 sessions of excimer light therapy

Table 1: Clinical and treatment details of patients (*n*=13)

Parameters	Mean±standard deviation/ median (range)
Age	25.9±12.1 years
Male:Female ratio	1.6:1
Type of vitiligo	Acrofacial vitiligo: Six, vitiligo vulgaris: Seven
Skin phototype	IV: Seven (53.8%) V: Eight (61.5%)
Duration of vitiligo	4.8±2.1 years
Number of narrowband ultraviolet B sessions before excimer therapy	148.8±92.2
Concomitant therapy	Tacrolimus 0.1% ointment: four cases, fluocinolone acetonide 0.1% cream: two cases, both: Six cases
Sites involved (*n*=25)	Head and neck: Seven, trunk: Ten, upper limbs: Two, lower limbs: Six
Number of excimer light sessions	21.4±8.3
Dose of excimer light	Head and neck: 550 mJ (450–700), trunk: 675 mJ (250–1000), upper limbs: 725 mJ (350–1100); lower limbs: 725 mJ (350–1500)
Patient global assessment	Improvement in four (30.77%) cases: 10% (0–25%) No improvement in nine (69.23%) cases
Investigator global assessment	Improvement in seven (53.84%) cases: 10% (5–40%) No improvement in five (38.46%) cases Exacerbation in three (23.07%) cases

According to physician global assessment, overall response ranging from 30 to 40% was recorded with a median overall improvement of 10% (range – 5–40%) observed in seven patients [Table 1]. Exacerbation of disease (defined as increase in the area of depigmentation from baseline) occurred in three cases. On comparing response according to the site of involvement, 80% repigmentation was found in only one case with facial lesion [Figure 1a and b] and 10–20% improvement was noted in two, three, zero and one patients with head and neck, trunk, upper limb and lower limb lesions, respectively. Side effects in the form of transient eyelid oedema and perilesional hyperpigmentation were seen in one case each. The latter probably resulted from the use of a larger-sized square stencil during delivery of excimer light.

Narrowband ultraviolet B is the standard therapy for vitiligo due to ease of administration and a good safety profile.[1] However, its delivery through the whole-body chamber is associated with inadvertent risk of phototoxicity to non-lesional skin and reduced efficacy at inaccessible sites like skin folds. Targeted phototherapy with excimer light overcomes these disadvantages and has been shown to produce more rapid and greater degree of repigmentation compared to narrowband ultraviolet B.[2,3] Casacci *et al*. recorded significantly higher mean repigmentation score (2.68 ± 1.35 vs. 2.12 ± 1.02, $P = 0.04$) achieved in significantly less mean number of sessions (21.6 ± 8.08 vs. 27.6 ± 10.2, $P = 0.004$) in 16 patients treated with excimer light compared to narrowband ultraviolet B.[3] Nevertheless, its role in producing repigmentation in residual vitiligo patches after narrowband ultraviolet B therapy has not been studied, as far as ascertained. In our small series, we did not find satisfactory response with excimer light despite excluding lesions over difficult to treat sites such as bony prominences, hands and feet. Clinically, perceptible pigmentation (>50% repigmentation) was observed in only one case. In a series, excimer lamp produced >50%

repigmentation in 66% of cases of refractory vitiligo.[4] The number of sessions in our series seems adequate, as repigmentation was noted after a mean of ten sessions in one study.[5] Three cases showed exacerbation, probably due to reversal of inhibition of immune response by halting whole-body narrowband ultraviolet B. Our study has limitations of being a retrospective one with a small sample size and a lack of control group. In conclusion, our preliminary study suggests that excimer light therapy is not effective for the treatment of residual vitiligo lesions following adequate whole-body narrowband ultraviolet B therapy. Surgical intervention followed by exposure to excimer light may be a better option for such recalcitrant lesions.

Declaration of patient consent

The patient's consent is not required as the patient's identity is not disclosed or compromised.

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Treatment practices amongst dermatologists in western India during the COVID-19 pandemic: A cross-sectional study

Sir,

India has the second highest number of COVID-19 cases after the United States of America. COVID-19 has affected the mode of consultation and prescription patterns in dermatology worldwide.[1,2] The aim of the study was to study the prescription patterns and practices among dermatologists during COVID-19 pandemic. An online questionnaire was sent via email and WhatsApp groups to dermatologists working in Rajasthan between 28 September 2020 to 1 November 2020. A total of 76 participants responded after giving informed consent. Out of all the questions, there was no response to a few questions (range 1–3 questions), as shown in Tables 1-3. Majority of the dermatologists, 43 (56.6%) were working in educational institutes and government hospitals followed by private hospitals 20 (26.3%). Thirty-three (43.4%) of the total participants were attending more than 50 cases per day before COVID-19, while only 21 (27.6%) participants were attending more than 50 patients per day during the pandemic. In India, telemedicine is not a commonly used mode of consultation, however due to the pandemic 39 (51.3%) dermatologists were using a telemedicine platform along with physical consultations. Dermatologists did not find telemedicine as a good mode of consultation every time. Thirty-one (40.8%) dermatologists found telemedicine consultation good in terms of diagnosis only sometimes (34–66% of time) [Table 1]. Specific reason for this was not asked from the participants but it may be related to poor quality images, mode used, need for systemic evaluation and a need for whole body examination.

COVID-19 can spread through asymptomatic individuals as well and therefore use of protective equipment is important. Forty-six (60.5%) dermatologists were using both mask and face shields, while 27 (35.5%) were using face mask alone during patient examination.

Majority i.e 50 (65.8%) dermatologists agreed that COVID-19 had affected their prescription pattern. Sixty-four

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