John E. Harris, MD, PhD, FAAD, is chair of dermatology, director of the Autoimmune Therapeutics Institute, and director of the Vitiligo Clinic and Research Center at UMass Chan Medical School.

He is a dermatologist and physician-scientist, caring for patients in a vitiligo specialty clinic and running a research laboratory focused on understanding disease pathogenesis and developing new treatments. His group integrates basic, translational, and clinical research strategies to accomplish this. As a result, clinical trials in vitiligo have shown success.

Dr. Harris founded Villaris Therapeutics (acquired by Incyte in 2022) and four other companies to develop treatments for inflammatory skin diseases.

Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with insights about what they should know about a specific subject area by the time they complete their residency.

Vitiligo pearls for residents

By John Harris, MD, PhD, FAAD

This is an exciting time for vitiligo patients and the dermatologists who care for them. Things are changing quickly, so here are my top five pearls to know about your patients with vitiligo.

1. **Vitiligo has a long history of social stigma, dating back to the Iron Age over 3,400 years ago.**
   This means there are many psychological implications to having the disease, influenced by complex social factors that may not be apparent or obvious in the clinic setting. In fact, multiple studies report that vitiligo can have a more severe impact on mental health than psoriasis or atopic dermatitis. Be sensitive to this, take your patients' concerns seriously, and make the time to develop a personalized treatment plan.

2. **When a patient presents to your clinic with vitiligo, the disease may be stable (unchanging for at least six months), or active (with increasing or enlarging patches).** This activity can be quite impressive, with affected body surface area expanding three-fold or more over just three months. Therefore, active vitiligo is important to recognize and treat to prevent this expansion, including the use of short-term systemic immunosuppression and starting nbUVB as soon as possible.

3. **There are four clinical signs that you can use to recognize active vitiligo in addition to obtaining a history of rapid expansion.** These include confetti lesions, characterized by 1-2mm macules of depigmentation clustered together; trichrome lesions, represented by zones of hypopigmentation at the border between depigmented and normally pigmented skin; inflammatory lesions, with erythema +/- light scale at the border of depigmented patches, often accompanied by itching; and the Koebner phenomenon, characterized by depigmentation following skin trauma, often appearing as linear macules from cuts or scratches. Use a Woods lamp in a darkened room to visualize these signs and the full extent of disease, particularly in lighter-skinned patients.

4. **Vitiligo is not associated with an increased risk of skin cancer, but rather a decreased risk.** A recent study reported that vitiligo patients have decreased all-cause mortality, with reduced infections, heart disease, and internal malignancies as well. This may be due to vitiligo patients having a particularly "strong" immune system, reflected by having vitiligo, an autoimmune disease. Also, nbUVB and topical calcineurin inhibitors do not increase this risk, so do not be afraid to treat your vitiligo patients with the long-term treatment required for slow repigmentation of their lesions.

5. **Set expectations for your patients when developing a treatment plan.** New effective treatments such as topical and emerging oral JAK inhibitors are exciting, but with all therapeutic strategies, repigmentation can take a long time, even two to three years, so patience and consistency during treatment is essential. Also, some parts of the body do not respond well to treatment, including glabrous skin (no hair follicles) or lesions with poliosis (white hairs), because the melanocyte stem cell reservoir is absent. DR

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