Clinical and Evolutionary Profile of Paediatric Vitiligo: A Tertiary Dermatology Centre Experience

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SUMMARY OF KEY RESEARCH FINDINGS

Vitiligo is a chronic acquired depigmenting disorder that frequently begins during childhood and may have a considerable psychosocial impact. Childhood vitiligo differs from adult disease in several clinical and epidemiological aspects,[1] while its visible nature may significantly affect quality of life.[2] Beyond its cutaneous manifestations, paediatric vitiligo raises challenges related to recognition of disease activity, therapeutic decision-making, long-term follow-up, and psychosocial wellbeing. Current expert recommendations emphasise individualised management according to age, disease activity, extent, location, and treatment goals.[3] Better characterisation of clinical and dermoscopic features may also facilitate recognition of active disease and treatment monitoring.[4,5]

This study aimed to describe the epidemiological, clinical, dermoscopic, therapeutic, and evolutionary characteristics of paediatric vitiligo in children managed at a tertiary dermatology centre.[6]

This retro-prospective observational study included 58 children younger than 18 years, with a mean age of 11.6±3.9 years and a female predominance of 58%. The mean age at disease onset was 7.1±3.2 years. Potential triggering factors were identified in 45% of patients, most commonly psychological stress (48%), followed by cutaneous trauma or Koebner phenomenon (34%) and intercurrent infections (18%). A family history of vitiligo was reported in 32%, while autoimmune comorbidities were identified in 12%.

The quality-of-life burden was substantial, with a mean Children's Dermatology Life Quality Index (CDLQI) score of 13.90±9.54. Facial involvement was the most frequent presentation, affecting 52% of patients. Dermoscopy revealed achromic areas in all patients, irregular linear and dotted vessels in 71.4%, central residual pigmentation in 50.0%, telangiectasia in 35.7%, and perifollicular depigmentation in 29.8%.

Treatment was individualised according to clinical presentation and disease activity. Topical corticosteroids were used in 92% of patients and topical calcineurin inhibitors in 69%. Systemic corticosteroid mini-pulses were prescribed in 23.0%, while 15.5% received narrowband UVB phototherapy. During follow-up, complete re-pigmentation was observed in 71.4%, partial re-pigmentation in 19.0%, and disease progression in 9.5%.[6]

These findings highlight the early onset, familial component, and considerable quality-of-life burden associated with paediatric vitiligo. They also demonstrate favourable re-pigmentation outcomes in most patients. Dermoscopy may represent a useful non-invasive adjunct for assessing disease activity and monitoring treatment response.[4,5]

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WHAT CHALLENGE DOES THIS ADDRESS?

Paediatric vitiligo should not be considered solely as a pigmentary disorder. Its visibility, particularly when the face is involved, may affect self-image, social interactions, and emotional wellbeing.[2] The substantial CDLQI impairment observed in this cohort illustrates that disease burden may extend beyond the objective extent of depigmentation. Incorporating quality-of-life assessment into routine evaluation may therefore help identify children requiring additional support.

Another important challenge is the early recognition of active disease. Distinguishing stable from progressive vitiligo is clinically relevant because disease activity may influence the timing and choice of therapy.[3] Although clinical examination remains fundamental, subtle signs of activity may be difficult to identify. Dermoscopy may therefore provide complementary information through recognition of vascular, residual pigmentary, and perifollicular patterns.[4,5]

RELEVANCE TO EUROPEAN PRACTICE

For HCPs across Europe, these findings reinforce the importance of early, comprehensive, and individualised management of paediatric vitiligo.

International expert recommendations support management based on disease activity, extent, site, treatment goals, and patient-related factors.[3,7] Clinical assessment should therefore consider not only depigmentation, but also psychosocial impact, treatment expectations, and the concerns of the child and family.

The predominance of facial involvement is particularly relevant because highly visible lesions may have a disproportionate psychosocial impact.[2] Psychological stress and cutaneous trauma also highlight the importance of therapeutic education, counselling, and attention to potentially modifiable aggravating factors. Dermoscopy may complement clinical examination and help document changes in disease activity and treatment response.[4,5]

WHAT ARE THE NEXT STEPS FOR THE RESEARCH?

The main limitations are the single-centre design, relatively limited sample size, and observational assessment of therapeutic outcomes. Larger prospective multicentre studies are needed to determine whether these findings are reproducible across different paediatric populations.

Future research should evaluate whether specific dermoscopic patterns can predict disease activity or therapeutic response and should incorporate standardised measures of vitiligo activity and re-pigmentation. Longer-term follow-up is needed to assess relapse, durability of re-pigmentation, and disease evolution into adulthood. Prospective studies should also explore whether structured psychosocial support alongside dermatological treatment can improve quality of life and overall disease management.

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