Dermatology Practical & Conceptual

Inflammatory Vitiligo

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Case Presentation

A 65-year-old man presented with multiple asymptomatic depigmented patches of varying sizes with an erythematous annular border over the upper back and shoulders for one week (Figure 1A). Histopathology from the border of one lesion revealed vacuolar interface changes and moderate perivascular lymphocytes with pigment incontinence in the superficial dermis. SOX10 staining revealed a reduction in epidermal melanocytes (Figure 1B). These findings were consistent with inflammatory vitiligo. After 2 weeks of 40 mg/day of oral prednisolone with a tapering dosage, the erythematous border had almost disappeared.

Teaching Point

The patterns of active and progressive vitiligo include inflammatory vitiligo, Koebner phenomenon, trichrome lesions, and confetti-like depigmentation. Inflammatory vitiligo is rare and characterized by erythema, scales, and pruritus at the border. Although the inflammatory phase is usually transient, it can cause rapid depigmentation [1]. Oral steroids are frequently used to stabilize rapidly progressive vitiligo, and ultraviolet phototherapy is another suitable treatment [2].

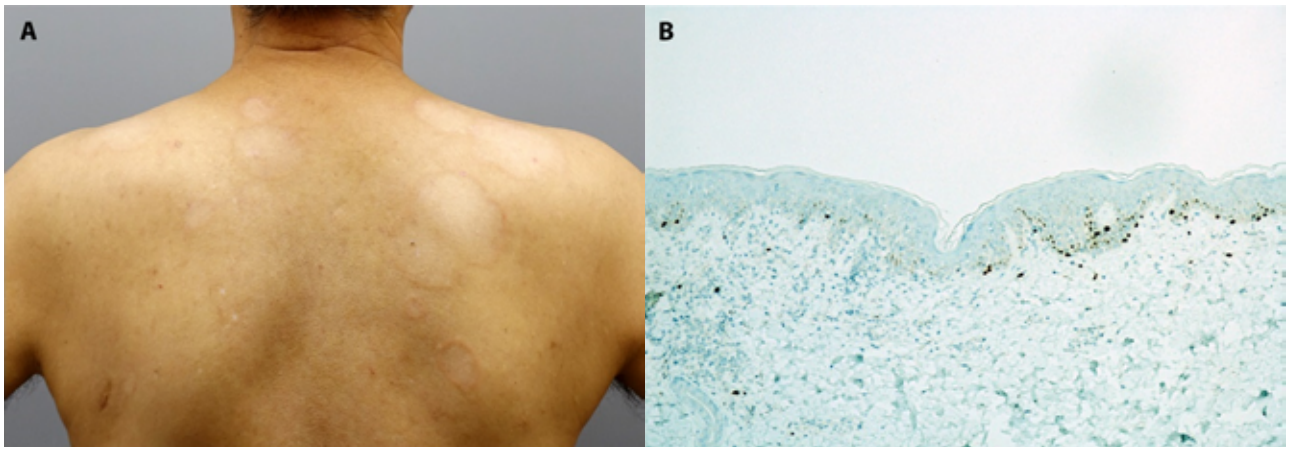

Figure 1. (A) Multiple asymptomatic depigmented patches with erythematous annular border over the upper back and bilateral shoulders. (B) Pathology with immunohistochemistry with SOX10 (100X): the right half of the figure from the erythematous border of the skin lesion shows the relatively normal distribution of epidermal melanocytes compared with reduced epidermal melanocytes in the left half of the figure from the depigmented area of the skin lesion.

References

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