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Correspondence Letter

Dear Editor,

Treatment recommendations for patients with vitiligo during COVID-19

The World Health Organization declared a global pandemic on 12 March 2020 due to the worldwide spread of COVID-19, caused by SARS-CoV-2.[1] Vitiligo is an autoimmune disease causing skin depigmentation affecting 0.5%–2% of the population. We do not project an increased risk of infection from COVID-19 in those with vitiligo, as the immune system of such individuals is not compromised and there is currently no evidence that the virus infects melanocytes. However, some patients may have treatment-related immunosuppression and some may have to access in-office narrow band ultraviolet light B (NB-UVB), which could increase their risk of developing COVID-19. At this time, there is a need to balance treatment for vitiligo with the need to reduce exposure to SARS-CoV-2. We have thus outlined the following treatment considerations to guide clinicians in the treatment of their vitiligo patients.

Topical agents can be continued, as they do not appear to cause systemic immunosuppression. NB-UVB is thought to act through local immunosuppression that is limited to the skin. We do not anticipate an increased risk of upper respiratory infections associated with COVID with the use of phototherapy.

Home phototherapy is safe to continue during quarantine, but precautions should be taken to prevent transmission for those accessing treatment in hospitals or private clinics. Pre-treatment symptom screening, increasing the time between consecutive patient treatments and cleaning all surfaces of phototherapy units between patients with a solution approved for use to combat COVID-19 is recommended.[2] Discontinuing phototherapy for more than 2 weeks is not recommended, as the beneficial effect of phototherapy wanes quickly and the patient may plateau or relapse. It is imperative to consider patient needs and desires during the pandemic. Working from home may positively or negatively impact the patient's ability to attend therapy. Furthermore, if patients are in a country or state where they must pay for phototherapy, the financial burden will need to be considered.

Lim *et al.*[3] have suggested avoiding treatment of facial lesions with targeted phototherapy (excimer laser). For extra-facial lesions, treatment interaction should be less than 15 min, and special precautions including surgical mask, gown, gloves and protective eyewear must be worn to avoid transmission of the virus.

Oral minipulse therapy with 2–5 mg betamethasone or dexamethasone, two consecutive days per week is used for patients exhibiting signs of progressive and aggressive vitiligo. While high-dose steroids increase the risk of infection, short-term or low-dose steroid regimens do not.[4] Thus, minipulse therapy is likely safe to continue during the pandemic. Methotrexate and azathioprine are occasionally used for those with rapidly progressive disease who are non-responsive to oral corticosteroid pulses. Given limited evidence of efficacy and increased risk for systemic infection, providers should heed caution when considering initiation of these therapies.[5] Recent publications suggest methotrexate doses, for example, could be lowered to 10 mg/week or less for those who are already on it.[6] Patients already on immunosuppression who show signs of COVID-19 infection or test positive for COVID-19 should discontinue the medication until they recover. Surgical treatment, such as grafting, should be deferred during the pandemic.

Targeted immunosuppressants such as JAK-inhibitors may be safer than less targeted agents, although data for them is limited. Baricitinib is being tested as a treatment to suppress the cytokine storm in those with COVID-19.[7]

At this time, there are no data on the effects of COVID-19 on vitiligo. Thus, we advocate an in-depth discussion of therapies with each patient and consideration of online consultations for reviewing patient progress.

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Correspondence Letter

Dear Editor

Simplified approach for digit identification in onychoscopy images

We read with great interest the article 'Numbered dots technique to standardise onychoscopy imaging' by Jayasree *et al*.[1] and found it a very novel and useful way of digit identification in onychoscopy images. In the same regard, we wish to propose the following approach which we believe would further simplify the process.

Each digit would be marked alphanumerically as illustrated in Fig. 1. Marking should preferably be made with a

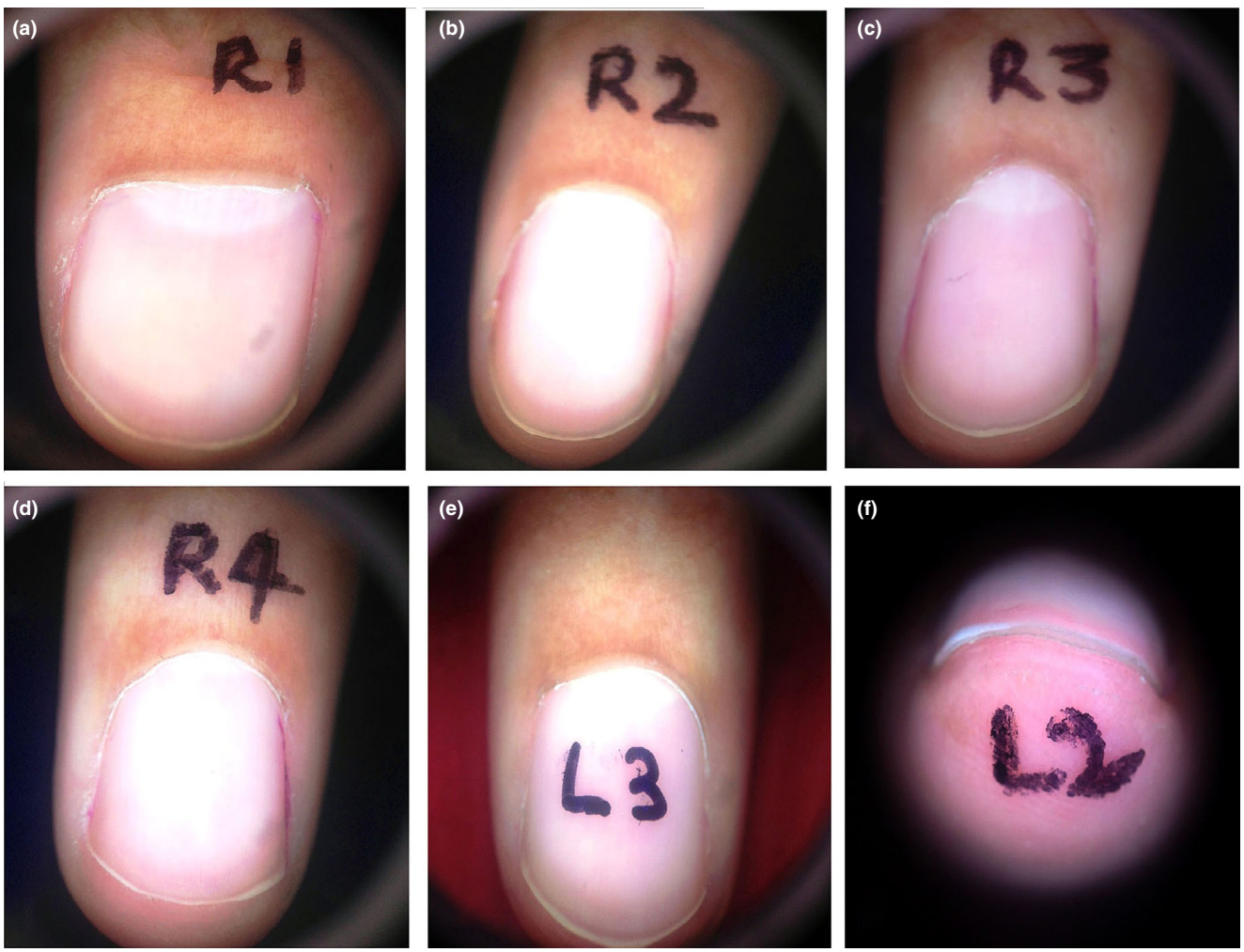

Figure 1 Alphanumerically marked digits for identification in onychoscopy images (a-f). Marking can be proximal (a-d) or distal (e) to the cuticle in order not to obscure features in the nail plate or nailfolds, respectively. Marking can be made at the tip of the finger pulp while capturing a frontal view image (f).