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Epidemioclinical Profile, and Pathological Associations of Vitiligo in Children

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ABSTRACT:

Vitiligo is a disease caused by progressive loss of melanocytes, often beginning in childhood. The aim of our work is to evaluate the epidemio-clinical profile, and pathological associations of vitiligo in children. Our serie have confirmed the predominance of childhood vitiligo. Although the pathogenesis and etiologies are still poorly elucidated, various triggering factors have been associated this dermatosis.

Keywords: Vitiligo – segmental – melanocytes - childhood

Introduction :

Vitiligo is a disease caused by progressive loss of melanocytes, often beginning in childhood. Positive diagnosis is easy in most cases, but there are certain characteristics different from those of adult vitiligo. It most often presents as localized white macules, often periorificial.

Materials and methods:

This is a retrospective descriptive study which collected 58 cases, involving children under 15 years of age, undergoing consultation at the dermatology department of UHC Mohammed VI in Marrakech, over a 10-year period (from 2014 to 2024). The aim of our work is to evaluate the epidemio-clinical profile, and pathological associations of vitiligo in children.

Results:

The mean age of our patients was 8 years. A clear female predominance was noted (69%). Mean duration of evolution was one year. Familial features were more pronounced (26%), autoimmunity was more or less marked (9%), and atopic dermatitis was associated in 10% of cases. Koebner's phenomenon was found in 19% of cases.

The main location was the face (24%), followed by the lower limbs (21%), the upper limbs (17.2%), then the perineal area (15.5%), the trunk (10.3%) and the back (3.4%). Focal vitiligo was found in 25 patients (43%), followed by segmental vitiligo in 22 patients (38%) and generalized vitiligo in 4 patients (6.8%). Finally, the acrofacial form was present in 7 patients (12%). Poliosis was noted in 3 children (5%).

Dermocorticoids were the first-line treatment for focal and segmental vitiligo, followed by tacrolimus, especially for the face. Oral corticosteroids in the form of “minipulses”: administration of an oral corticosteroid (bethametasone or methylprednisolone) on 2 consecutive days a week for 12 to 16 weeks, in combination with UVB phototherapy was prescribed in acrofacial forms. The onset of treatment, was greater than three months.

Discussion:

Female predominance has been reported in all pediatric series (1). The incidence of a family history of autoimmune varies between 3.3% and 27.3% (1). This is more frequently in children than in adults. Segmental vitiligo is characterized by unilateral lesions that do not extend beyond the midline Blaschko lines (1). The evolution of vitiligo is variable: it can be stable, progress or sometimes disappear completely. Non-segmental forms of vitiligo seem to progress than segmental vitiligo. Lesions of segmental vitiligo are generally more resistant to treatment (2). The most frequent location in the literature is the face, followed by the trunk, neck and limbs. In non-segmental vitiligo, the face, hands and face, and friction zones are the most affected areas. The back is more often spared than the abdomen. Involvement of the perineum and perianal region is a classic localization in young children, and often

represents the mode of entry into the disease. Scalp involvement in vitiligo ranges from 12.3% to 19.3% (1). Koëbner's phenomenon has been little studied in childhood vitiligo. Handa and Dogra observed it in 11.3% of children (1).

Several topical or systemic treatments are available for children. The onset of action is often long, lasting more than two or three months. The first thing to do is to explain to the family the importance of limiting rubbing, which is an aggravating factor and a cause of treatment failure. Psychosocial support is important whatever the clinical form, from the moment the diagnosis is evoked (1, 3).

Conclusion:

Our series and analysis of the literature have confirmed the predominance of childhood vitiligo. Although the pathogenesis and etiologies are still poorly elucidated, various triggering factors have been associated this dermatosis. And although vitiligo is not a life-threatening condition, it can significantly impair quality of life. Children are likely to be affected differently depending on the location of vitiligo on visible or non-visible areas, extension and evolution, age and family environment.

References:

1- A. Ammour a, T. Jouary b, A. Taïeb b, J. Mazereeuw-Hautier, Vitiligo in children - 2010 French Society of Pediatric Dermatology

2- Professor Juliette MAZEREEUW Vitiligo in children- 2024 Reference Center for Rare Skin Diseases and Mucous Membrane Diseases Hôpital Larrey - Dermatology Department Toulouse, France

3- VITILIGO IN CHILDREN Experience of the dermatology department at the Moulay Ismail Military Hospital, Mèknes (25 cases)

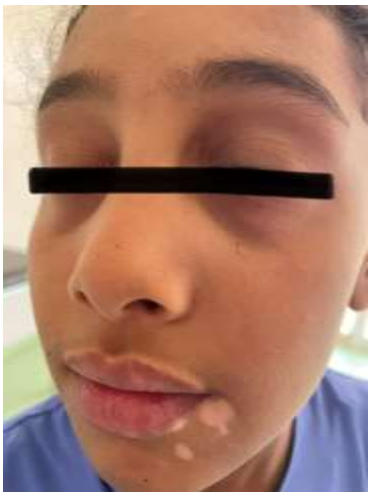

Figure 1: Periorificial vitiligo

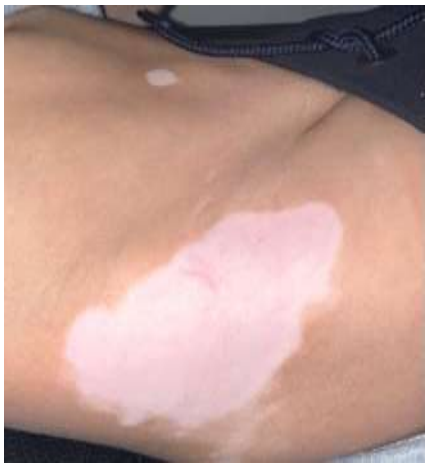

Figure 2: Segmental vitiligo of the thigh right

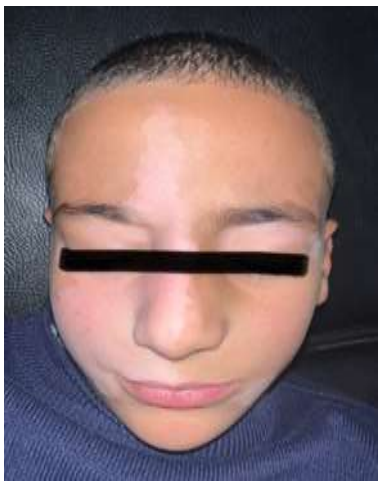

Figure 3: Segmental vitiligo of the face