VGICC participants to first round of discussions, Seoul, WCD, Coex conference, Room 318 May 24, 2011

First Name	Name	Region	Town, country
AFRICA			
Laila	Benzekri	Africa	Rabat, Morocco
Noufal	Raboobee	Africa	Durban, South-Africa
AMERICA (Coordinators Henry Lim and Caio de Castro)			
Henry	Lim	North America	Detroit, USA
John	Harris	Worcester, Mass, USA	
Pearl	Grimes	North America	Los Angeles, USA
Richard	Spritz	North America	Denver, USA
Harvey	Luit	North America	
Yowen	Zhou	North America	ancouver, Canada
Maria Lucia	Barona	South and Latin America	Comobia
EUROPE (Coordinators Alain Taieb and Mauro Picardo)			
Alain	Taieb	Europe	Bordeaux, France
Khaled	Ezzedine	Europe	Bordeaux, France
Yvon	Gauthier	Europe	Bordeaux, France
Thierry	Passeron	Europe	Nice, France
Mauro	Picardo	Europe	Roma, Italy
Inka	Nieuweboer	Europe	Amsterdam, Netherlands
MIDDLE-EAST (coordinator Tag Anbar)			
Mahmound	Abdallah	Middle East	Cairo, Egypt
Medhat	El-Mofty	Middle-East	Cairo, Egypt
Bakr	El Zawahry	Middle East	Cairo, Egypt
Yasmin	El Zawahrt	Middle East	Cairo, Egypt
Continental Asia/Singapour (coordinator D Parsad (India) and BK Goh (Singapor))			
Boon Kee	Goh	Continental Asia	Singapour
Davinder	Parsad	Continental Asia	India
Hema	Jerajani	Continental Asia	India
SK	Hann	Continental Asia	South Korea
Ai-Young	Lee	Continental Asia	South Korea
Japan/Taiwan (coordinator HS Yu/E Lan (Taiwan) and I Katayama (Japan))			
Ichiro	Katayama	Japan/Taiwan	Osaka, Japan
Kazuyoshi	Fukai	Japan/Taiwan	Osaka, Japan
Naoki	Ohiso	Japan/Taiwan	Kindai, Japan
Tamio	Suzuki	Japan/Taiwan	Yamagata, Japan
Marahiro	Hayashi	Japan/Taiwan	Yamagata, Japan
Cheng che Eric	Lan	Japan/Taiwan	Kaoshiung,Taiwan
Pacific (coordinator P Kumarasinghe)			
Prasad	Kumarasinghe	Pacific	Australia
Richard	Wittal	Pacific	Australia

Minutes of the Meeting

Introduction: Prof Alain Taieb gave a short presentation of the history and rationale of the agenda of this first international consensus conference on Vitiligo The second and last part will be held in Bordeaux, Tuesday September 20, before the International Pigment Cell Conference, and a draft should be circulated before to prepare this final discussion. A concurrent session of IPCC will present the results of the consensus on Sat 24 September, and a consensus paper should be sent for publication by the end of this year.

Session 1: Classification of vitiligo :chaired by Dr Mauro Picardo, Prof Hann and Dr Prasad Kumarasinghe

Dr K Ezzedine from Bordeaux, France presented the summary of the contributions submitted by the various groups from different parts of the world.(see annex-I) After the submissions were presented to the whole group, each and every participant was given an opportunity to present his/ her views. All the delegates agreed that **segmental vitiligo** is to clearly differentiate from the other types of vitiligo. It is important to recognize this fact for treatment and prognostic reasons. All agreed that although autoimmune phenomena can occur in association with segmental vitiligo, it is very minimal compared to non segmental (generalized) vitiligo. It was pointed out by Prof Hann and a few others that segmental vitiligo can coexist or precede generalized vitiligo. Also two photographs of twins; one with segmental vitiligo and the other with generalized vitiligo was also shown.

Several delegates expressed the view that the category **'nonsegmental' vitiligo** is not very appropriate, but as it was felt that separating segmental vitiligo from other types was more important, it was decided to keep the term non segmental vitiligo, to describe vitiligo types other than segmental vitiligo as an **umbrella term**.

Prof Richard Spritz briefly explained the recent findings in the genetics of nonsegmental vitiligo, and the associations with other autoimmune disorders.

Prof Pearl Grimes felt that **occupational vitiligo** should be a separate category, as it behaves different to others and usually a history of occupational exposure to certain chemicals such as phenolic chemicals can be obtained.

Dr Prasad Kumarasinghe proposed to exclude the confusing term **'vitiligo ponctue'** from the classification of vitiligo, as it may not exactly be vitiligo. He proposed to call it **punctate leukoderma if it is not associated with definite vitiligo**. Many delegates agreed that this term may have been used in the past to describe with depigmentation at the hair follicles in vitiligo patients or punctate leukoderma secondary to UB treatment or natural sun light exposure.

Taking into account the ideas expressed at this meeting, the following classification can be put forward. This can be further discussed at the Bordeaux Meeting in September. Based on the results of the discussion it was decided to ask the chairmen to evaluate the eventual modification of the term “non segmental“.

1. Segmental vitiligo
2. Non segmental vitiligo - Focal, Acrofacial, Generalised, Mucosal, Universal

3. Mixed type of vitiligo (segmental and non segmental in the same patient)
4. Occupational vitiligo

Other points have been noted:
The term vulgaris should be avoided, the terms unilateral-bilateral may be confusing.
The need for a prognostic classification distinguishing hypochromic vs achromic macules was deemed interesting but considered as premature/ pathophysiological vs clinical/trichrome pattern/ follicular –punctata-post phototherapy to better delineate: circulate photographs

Session 2: Definition of stable disease chaired by N Raboobee, Y Zhou,
Introduction by E Lan (See annex)
Several questions concerning the issue of stability have been discussed. In particular, the following points arise:

1) How to assess clinically stability:
Pr L Benzekri said "Should we consider stability of lesion taken individually or should we assess global stability since in the same patient some lesions may be stable while others are not".
Other asked if clinical assessment should be considered from the patient's perspective?

2) The second issue for stability concerned its duration:
What should be taken into account to calculate this duration: the disease-free period or rather the absence of progressive disease without any therapy?
For instance there is no consensus and stability may be defined for a period of 3 months without progression until 2 years. This issue needs further discussion and a consensus between all experts is needed as it may drives therapeutic intervention. In particular when should we consider surgical intervention?

3) Is there a need for biopsy to assess stability?
This may be done through the absence/presence of an inflammatory infiltrate at the margins of the lesions?

4) Of major prognostic interest, the distinction between NSV, which is overall unpredictable, and SV should be stated with regard to stability issue.
The classification of head and neck vitiligo presented by Dr Hann should be put on the agenda for further meetings.

Session 3: Definition of Koebner phenomenon: chaired by I Katayama, L Nieuweboer-Krobotova and Y Gauthier

1) The link between Koebner and stability has been hardly discussed. Should these two issues belong to the same chapter?
Once again, the stability and its importance for practice as an essential point of prognosis has been discussed. Prognosis should guide surgical grafts.

2) With regard to Koebner phenomenon, we should differentiate between clinical Koebner phenomenon (KP), the past history history of KP and experimentally induced KP (see European position paper)
However, there is still a need for a simplified and accurate method of assessment of KP.

3) Another point of this issue was the debate on sun exposed areas: at the onset of vitiligo significant injury appears to be required to induce Koebnerization such as mechanical traumas, chemical damages, but also in sparse cases UV radiations damages. Is it only Koebner phenomenon linked to sunburn or just ongoing progressive vitiligo not stopped by UV treatment?
So, does the entity "photosensitive vitiligo" exist? Is it connected with Lupus?

Session 4. Definition of "autoimmune vitiligo" chaired by AY Lee, R Spritz

Introduction BK Goh (Annex)
Dr Goh questioned in his introduction on the need for grading autoimmunity in vitiligo.

There was a clear consensus to differentiate between NSV and SV with regard to this issue.

1) NSV
The following questions were raised :
Is autoimmunity in vitiligo linked to the association with autoimmune diseases?
Should we consider local auto-immunity/inflammation *vs* general autoimmunity?

Clearly, NSV is always, at least partly, driven by immune-mediated autoinflammatory mechanisms

The role of Tregs (circulating versus homing) as well as the involvement of Th17 pathway needs further investigation. Pr Spritz has pointed out the recent findings on tyrosinase gene implication in NSV and made a comparison with diabetes as an organ autoimmune disease..

In conclusion, there may be multiple steps leading to autoimmunity or immune-mediated autoinflammation in NSV.

2) Segmental vitiligo
With regard to SV, arguments for immune-mediated auto-inflammation are less convincing (see the recent report by van Geel et al of a an immuno-histochemical study in patient with SV and halonevi)

Concluding remarks by H Lim, D Parsad, A Taïeb

The conclusions of the meeting emphasized the preparation of the agenda of the next meeting at IPCC and indicated further priorities for the international agenda.

- QoL in vitiligo patients
- What is the safety profile of the combination of tacrolimus + UV
- Outcome measures standardization especially for repigmentation.

Next part of the international agenda


24/05/2011