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Innovations

Quick and effective solution for perigraft halo in difficult cases

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ABSTRACT

Surgical management, especially grafting, can provide an effective solution to long-standing stable vitiligo in most cases. However, the resultant perigraft halo can be difficult to manage at times, as patients are not willing to undergo repeat surgery, and methods such as phototherapy, 88% phenol, microneedling, and 5-fluorouracil can fail. We herein describe a simple, quick, and effective solution for the management of perigraft halo that failed to respond to other modalities.

Keywords: Dermatosurgery, Motorized punch, Perigraft halo, Vitiligo

PROBLEM STATEMENT

A 23-year-old man underwent suction blister grafting (SBG) 10 months ago for focal vitiligo on the left side of his lower lip. He was, however, bothered by the perigraft halo which had subsequently developed [Figure 1]. The perigraft halo had failed to repigment despite repeat SBG, phototherapy, 88% phenol, microneedling, and 5-fluorouracil. The patient did not consent to tattooing and wanted a permanent solution.

RECOMMENDED SOLUTION

Using the hair transplant follicular unit extraction (FUE) motorized punch (0.7 mm), we punched multiple areas of skin in the perigraft halo to the mid-dermis level after achieving local anaesthesia. Care was taken not to place two punches <1–1.5 mm apart so that healing is faster without any residual scarring [Figure 2]. This method also allowed us to remove leukotrichia simultaneously. The area was left to heal with secondary intention. After 1 week, the site had almost completely healed with a reduction in the depigmented area. Further two sittings allowed us to achieve complete repigmentation of the perigraft halo [Figure 3]. FUE was done 6 months after SBG and since the repigmentation started occurring around the areas that were punched, we were sure it was because of FUE and not SBG. Surgical excision and punch grafting of a vitiligo patch are known modalities for the treatment of recalcitrant vitiligo.[1] However, the result may not be cosmetically acceptable to the patient and they are time-consuming. We overcame these limitations using a small-sized (0.7 mm) motorized punch, which removed only small areas of depigmented patch at a time and overcame complications such as cobblestoning and scarring. Furthermore, post-inflammatory hyperpigmentation induced by therapeutic trauma might have

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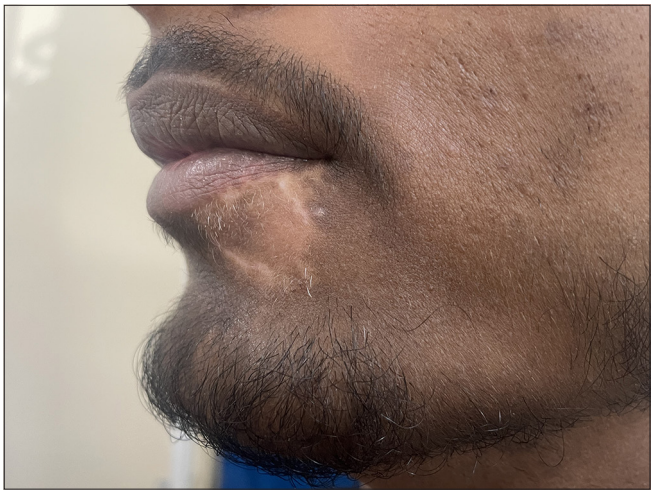

Figure 1: Pre-operative picture of perigraft halo near left side of lower lip.

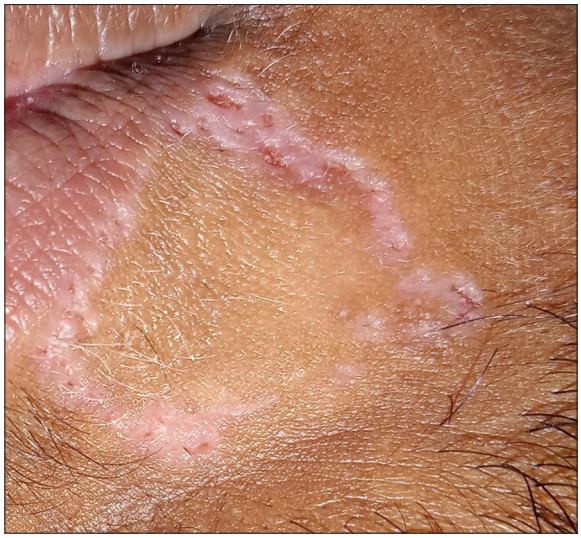

Figure 2: Post-operative picture showing punched areas of depigmented skin in healing stage.

aided in achieving repigmentation.[2] However, the results of this method may not be uniformly reproduced in all patients due to the heterogeneous nature of vitiligo in patients of different ethnicities.

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Figure 3: Complete repigmentation of perigraft halo after 3 sittings.

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