The National Vitiligo Foundation

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NATIONAL VITILIGO FOUNDATION

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Vitiligo Foundation Begins New Era

The National Vitiligo Foundation was founded in 1985 by Allen and Nancy Locklin of Tyler, Texas. Beginning in 1999, the NVF became part of the Trinity Mother Frances Health System (TMFHS) Foundation, also in Tyler. This month, we begin a new era as an independent, non-profit organization.

Thanks to TMFHS

We are grateful to the TMFHS and their Foundation for providing a home and support during the past five years. We especially thank the staff of the Foundation, C.C. Baker, former vice president for the Foundation; Beverly Mason, current vice president ; and Lindsey Bradley, President and CEO for Trinity Mother Frances Health System. "Without the guidance and support of the Trinity Mother Frances Hospital Foundation, this transition would not have been possible, " said Dr. Ronald S. Davis, NVF Board Chairman. Finally, we are extremely grateful for the Foundation's generous gift to assist us in our new endeavor.

> "Without the guidance and support of the Trinity Mother Francis Hospital Foundation , this transition would not have been possible, " said Dr. Ronald S. Davis, NVF Board Chairman.

New Director

As part of this new era, the NVF hired Anna K. Hayes to serve as Director. Ms. Hayes has 15 years experience in non-profit and governmental management , grant-writing and membership services. Ms. Hayes also has a background in financial planning, and we are excited to have her on board to serve you.

We plan to expand our member services, publish a quarterly newsletter, and, of course, continue our research funding.

20th Anniversary

Next year we also celebrate our 20th Anniversary. We will be announcing special events and fundraisers for this special year.

Please contact Anna by email or phone for any assistance you may need .

White patches and bruised souls: Advances in the pathogenesis and treatment of vitiligo

Pearl E. Grimes, M.D.

Vitiligo is a common acquired disorder characterized by patches of depigmentation. The frequency varies from 0.1% to 2% in various global populations. Twenty to thirty percent of patients report vitiligo in first- or second-degree relatives. Genetic data support a non-Mendelian, multi-factorial, polygenic inheritance.

Vitiligo does not discriminate. It affects all races, skin types, and ethnicities. Given the stark contrast between depigmented and normal skin, the disease is most disfiguring in darker racial ethnic groups. Vitiligo is no doubt one of the most psychologically devastating diseases in dermatology. In a society obsessed by appearance, patients are often stigmatized, traumatized, and ostracized. Children are frequently teased and ridiculed by their peers. Adults experience low self-esteem and job discrimination. In India, vitiligo

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We Need Doctors

The National Vitiligo Foundation needs to update our Physicians list on our website. If you treat vitiligo patients and would like to be included on our website, please email your information to info@nvfi.org. We are looking for:

Name
Address
Phone Number
Fax Number
Specialties

Thanks for your assistance. Should you have any questions, please contact Anna at 903-595-3713.

Vitiligo Bulletin On-Line

The *Vitiligo Bulletin* is available on our website, nvfi.org. You will need Adobe Acrobat Reader® to view the newsletter. Acrobat Reader® can be downloaded for free at adobe.com. Newsletters can be read for free through December. Beginning in January, you must be a member of the National Vitligo Foundation to access the *Bulletin.* A registration and log-on feature will be added to the website during the month of December. See the back page for membership information or go to "Contributions" at nvfi.org to join using your Mastercard © or Visa ©.

Letter From the Chairman

Dear Friends:

During the past year we have been working on significant changes within the National Vitiligo Foundation. We believe these changes will provide you with enhanced services and more current information on vitiligo.

- We are once again an independent non-profit organization. Please note our new address, phone, fax and email on the letterhead,
- We have a new director, Anna K. Hayes. Anna has 15 years experience with non-profit management, fund-raising and membership services. She is very excited about the opportunity of helping you and expanding the services of the Foundation.
- The newsletter will now be published quarterly and our website will be more frequently updated to keep you up to date on the latest information. Because of continuing increases in printing and mailing costs, the newsletter will be published on-line and, if desired, sent to members by email as soon as it is published. For those who would prefer a hard copy, this will be available for a small additional fee (see Membership is Vital on the back page).

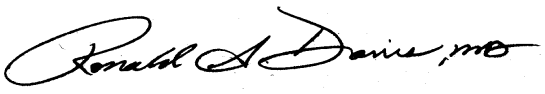
Our plans for the future include further changes to our website and greater efforts to increase public awareness of vitiligo.

- We are in the process of updating our physician locator.
- There will be a "Members Only" section on our website with special features such as interviews with the leading experts on both the physical and psychological experts on vitiligo.
- We will be working with insurance companies to provide coverage for treatment.
- Working with NIAMS and the American Academy of Dermatology Association, we will increase our efforts to educate the public about vitiligo.
- Increase our grants to fund vitiligo research.

All our efforts are for you, our members, so your input is extremely important to us. Please write or email us if there are additional items or features you would like to see in the newsletter or on the website.

Please remember it is your donations that make all this possible, especially the research that will some day lead to better treatment. Please consider a donation above the Basic Membership level. There is no way we can thank you enough for your support throughout the 20 years of the Foundation's existence. We hope that you will continue that support and please consider making a donation above the Basic Membership level.

Sincerely,



Ronald S. Davis, M.S., M.D.

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White patches and bruised souls, cont'd.

(Continued from page 1)
is often considered "white leprosy," and the stigma of the disease has major societal implications. It interferes with marriage prospects; it causes marital discord, and divorces are common.

In order to grasp the true psychosocial significance of vitiligo, one must view the disease within the context of the societal perception of pigmentation. Pigmentation influences the daily paradigm of psychosocial interactions. In America and throughout the world, the perception of an individual's health, wealth, worth, and desirability is often influenced by the color of their skin. Any aberration in pigmentation can be perceived as further alienation from society.

Our institute has evaluated countless men, women, mothers, fathers, and children, and often during these consultations, the participants are consumed by intense emotion, often straining the composure of the provider.

I must share the case of a 3-year-old with vitiligo that I followed for 2 years. On a follow-up visit, as I entered the examination room, my young patient immediately pointed to a depigmented area on her brow and shouted, "Doctor, I want you to fix it. Please fix it now!" It is evident that the psychological implications of the disease are myriad and deeply manifested even at an early age.

The precise cause of loss of epidermal melanocytes in vitiligo is unknown. Autoimmune, biochemical, oxidative stress, autocytotoxic, and neural mechanisms have been proposed. Gauthier et al[1] recently proposed a new theory of melanocytorrhagy based on the in vivo observation of melanocyte detachment from the basal cell layer followed by trans-epidermal migration and death of melanocytes.[2] Autoimmunity remains the most popular hypothesis. Autoimmune diseases, in particular Hashimoto's thyroiditis, are increased in patients with vitiligo. In addition, a plethora of humoral and cell-mediated immune aberrations have been characterized.

Autoantibodies targeting melanocyte surface antigens and cytoplasmic antigens are numerous.

Recent studies have added additional insight regarding cell-mediated immunity in the destruction of melanocytes.[1-2] Increased numbers of circulating melanocyte-specific cytotoxic T-lymphocytes have been reported. Cytotoxic T-lymphocytes with skin homing receptors (CLA+) have been identified at the margins of vitiliginous lesions. These cells have been identified in apposition to disappearing melanocytes in the perilesional skin of generalized vitiligo. Such observations suggest that CLA+ cytotoxic T lymphocytes may play a key role in the destruction of melanocytes. Recent investigations have reported an increase in local cytokine production. These cytokines include tumor necrosis factor (TNF)-, interferon-, and interleukin 10 in the lesional and/or lesional and adjacent normal skin of patients.[3] TNF- and interferon- are mediators of apoptosis, another potential mechanism for melanocyte destruction. TNF- also inhibits melanocyte proliferation and melanogenesis.

Whether these immunologic aberrations are primary or secondary events in the destruction of melanocytes in vitiligo remains an intensely debated topic among pigmentation researchers. However, regardless of which event is primary, many of our most effective therapies for vitiligo work via suppression or modulation of the immune response. Credible evidence supports each of the aforementioned theories. Vitiligo may well represent a heterogeneous disease with multiple etiologies. Alternatively, a "convergence theory" suggests multiple mechanisms may simultaneously contribute to the final destruction of the melanocyte.[2]

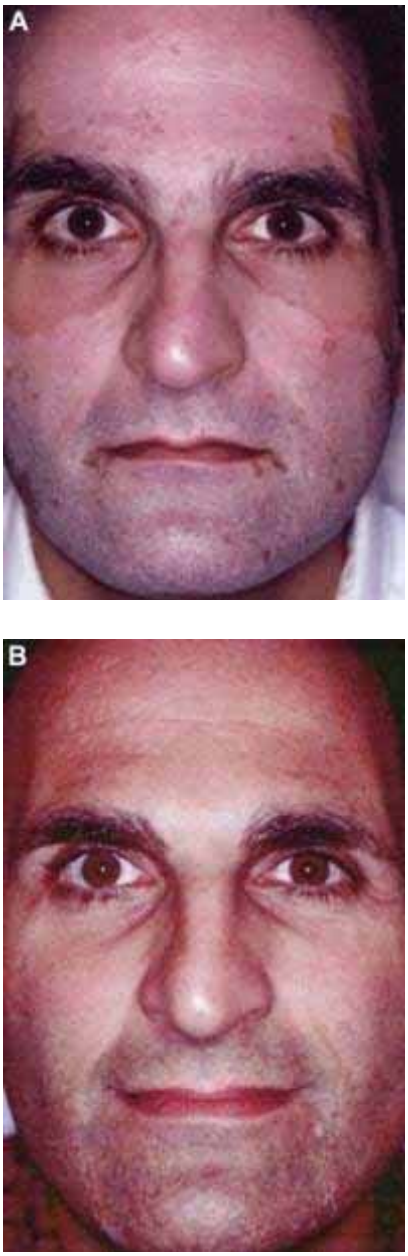
Historically, vitiligo has been and remains a therapeutically challenging and difficult disease. For decades, physicians perpetuated the notion that all treatments for vitiligo were ineffective. In the past, the gold standards of treatment were oral and topical psoralen photochemotherapy and topical corticosteroids. At best, none were optimal.

In the past 6 years, there have been exciting, new, and efficacious therapeutic advances for vitiligo. These include narrowband ultraviolet B (UVB) phototherapy, targeted light/excimer laser therapy, topical immunomodulatory therapy, and calcipotriol in combination with ultraviolet light.

Narrowband UVB is now the treatment of choice for patients with moderate to severe vitiligo. Since the original investigation by

(Continued on page 4)

Fig 1. A, A 44-year-old male with vitiligo. Disease had been recalcitrant to topical steroids, topical PUVA, oral PUVA, and narrowband UVB. **B,** Repigmentation after 7 months of tacrolimus 0.1% ointment twice daily.



Advances in Vitiligo Treatment, cont'd.

(Continued from page 3)

Westerhof and Nieuweboer-Krobotova,[4] several studies have further documented its efficacy and safety in children and adults. The major advantages of narrowband UVB include ease of treatment, lack of need for post-treatment ocular protection, and lack of systemic side effects. Unlike psoralen plus ultraviolet A, phototoxic reactions are minimal, and no increase in skin cancers in vitiligo patients treated with narrowband UVB has been documented.

Targeted phototherapy systems have recently proved effective for treatment of localized vitiligo. In 1999, Lotti et al[5] reported the effectiveness of UVB radiation microtherapy for repigmentation of segmental vitiligo. Subsequent investigations have documented the benefits of excimer laser systems and targeted phototherapy units. These units offer several advantages over full body systems. Full body UVA and/or UVB units affect both diseased and normal skin, whereas targeted light sources deliver high-intensity light exclusively to depigmented patches. Rapid therapeutic responses have been reported, which may facilitate lowering cumulative UV dosing.

Grimes et al[6] first reported the efficacy of tacrolimus ointment for repigmentation of vitiligo. Tacrolimus inhibits T cell activation, thereby blocking the production and release of pro-inflammatory cytokines. Other investigators have also documented the efficacy of tacrolimus as a repigmenting agent in children and adults with vitiligo. Maximal results occur in sun-exposed areas of skin (face/neck sites). A recent study documented a decrease in TNF- expression in lesional and adjacent skin after 6 months of tacrolimus therapy, thereby suggesting that suppression of TNF- may be associated with repigmentation of vitiliginous skin lesions.

Calcipotriol has been reported to induce repigmentation of vitiligo when used in combination with sunlight, psoralen plus ultraviolet A, or narrowband UVB. Melanocytes are thought to express 125-dihydroxy vitamin D3 receptors. Hence, calcipotriol may play a role in stimulating melanogenesis as well as modifying defective epidermal calcium homeostasis in patients with vitiligo.

The pioneering work of Falabella popularized autologous grafting procedures for depigmented lesions. Autologous grafting for vitiligo continues to evolve. Grafting procedures are indicated in patients with stable, localized patches that have failed medical intervention. Therapies include suction-blister grafts, punch grafts, melanocyte cultures, and co-cultures of melanocytes and keratinocytes. A recent literature analysis provided further insight regarding factors which portend favorable surgical outcomes.[7] Maximal results are achieved in patients with segmental vitiligo and in individuals less than 20 years of age.

These advances are substantial. The future is indeed promising for vitiligo patients. As clinicians engage these new and exciting therapies, they move beyond their acceptance of the proverbial myth: "nothing works for vitiligo."

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"You may have bruised your soul trying to fit into an infamous space known as the Diaspora. But, the beauty is in the fact that the soul can only be bruised and not maimed. And, bruises do heal!"

—Jorga Mesfin, quoting his father

Fighting and living with vitiligo

By
Michael Austin

Vitiligo is worse than diabetes. I don't know any doctors who agree with that assessment. The insurance companies that tell you vitiligo is just a "cosmetic" problem certainly don't agree. And neither do the government agencies that fund medical research. But I'm a patient who lives with both conditions and I can't help comparing them. I know at some point in the future I could die from the physical complications of type 1 diabetes. But in my experience, the deep psychological pain of vitiligo is every day a more destructive force in my life.

It began in 1990 with just one spot on my face, then another and another. I went from dermatologist to dermatologist. Each told me there was no cure, no really effective treatment, and they seemed sort of disinterested when I spoke of the dramatic change I saw in the mirror. A shrug of the shoulders. Too bad.

Many months later, the spots were now growing together and I was starting to feel desperate. I was a fairly good-looking single guy in my early thirties living in southern California, watching my skin turn blotchy, and, in my mind, ugly. At first I tried to cover it up, growing a beard to mask the vitiligo on my chin, and later wearing special makeup. I tried to blend away the horrible circles around my eyes and the marks on my forehead, but it didn't look natural. The fact that I was a man who had to use makeup really took a toll. My self-confidence was shot. Who was going to go on a date with me, much less marry me? How would this impact my life? Would it spread even more? I wanted to run and hide. I thought, Don't let anyone get too close. They may not notice. Yes, this was worse than diabetes.

Somehow I could manage the diabetes and conceal it, but vitiligo is worn like a badge, out there for all to see. I began noticing others with vitiligo, many who suffered much more…the little girl in Los Angeles teased by mean kids, the African American man I will never forget in Memphis, devastated by the white spots.

Finally, I found a doctor who offered hope and empathy, but who still had no way to stop the vitiligo. We tried several kinds of light therapy. Office visits two to three times per week took over more of my life. The oral psoralen made me feel sick. I wore stupid glasses to protect my eyes. I felt really sorry for myself, although I told myself it could be worse…I could have cancer or some other fatal disease. But those thoughts simply didn't alter the reality of how my appearance had changed, how society judges based upon appearance, how I felt differently about myself.

That was the worst part of the vitiligo. My feelings about myself had changed. I knew pragmatically that this disease was just on the skin, on the surface, but emotionally it left a very deep scar. I felt my life was ruined. After more than a year of PUVA and then narrowband UVB, the vitiligo was not better, it was still spreading, and when my doctor said it was time to call it quits with those treatments, I cried uncontrollably.

And I became even more determined. I went to medical school libraries to read the latest studies about vitiligo. I traveled to a dermatology convention. I joined the National Vitiligo Foundation. I learned about all kinds of wild and crazy potions and procedures in far-off places. I got depressed and angry that there was so little serious research about a condition that hurts millions of people around the world.

Then my doctor asked if I would participate in an approved study of isoprinosine, a drug that might modulate the body's autoimmune destruction of pigment-producing cells. After taking six tablets a day for six months, there was marked improvement. After a year, all the vitiligo on my face was gone! I was extremely happy. I felt my long nightmare was over. Was the huge improvement a coincidence, a miracle, or proof of an effective treatment? I believe the isoprinosine did work, but not for long. During another year of taking the medication, the vitiligo crept back, and so did my despair.

Eventually, I wondered if the problem wasn't in my head more than my skin. After months of therapy with a psychologist, there was no telling diagnosis, just the realization that I was going to have to accept vitiligo over the long term. I was going to have to strike a balance between my fight with this condition and a desire to enjoy my life.

I owe a lot to the kindness of a caring dermatologist and other patients, even if my struggle with vitiligo continues. I'm now using tacrolimus ointment. It seems to work well to stop vitiligo on the face, but not as well on other areas. So I still search for a better treatment, and still pray for that elusive cure. But now, more than a dozen years after I first encountered this disease, there are days when I look in the mirror and I don't see the vitiligo. I just see me.

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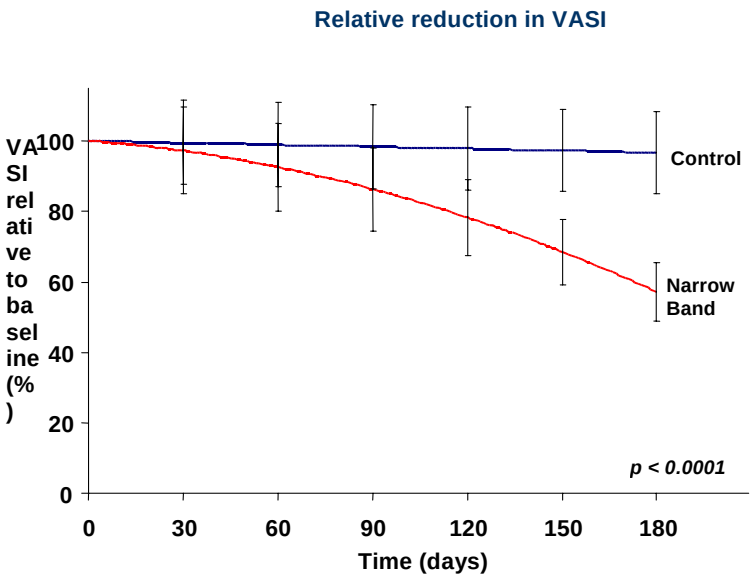
Update on Clinical research for vitiligo: The VASI score

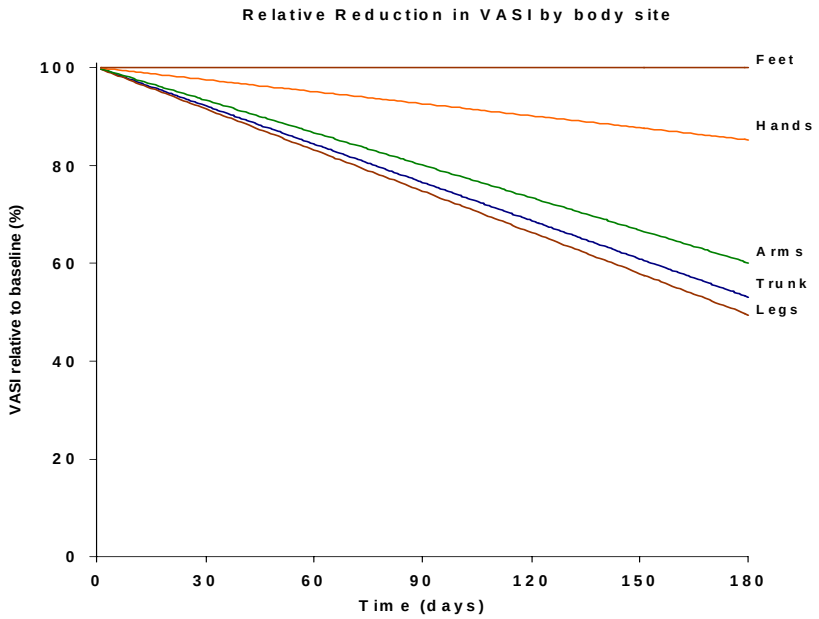
By
Iltefat Hamzavi, MD
Clinical Assistant Professor
Department of Dermatology
Wayne State University

When patients or physicians try to determine how well a particular treatment works for vitiligo, it is often difficult to compare different treatment options. There is no standardized measure for the amount of vitiligo someone has and how it responds to treatment. There is a standard for psoriasis known as the PASI (psoriasis Area and Severity Index) score, which has been quite helpful in comparing different treatment options in numerical terms. The PASI has been the basis for the FDA in its evaluation of the rapid increase in new psoriasis treatments. This is not the case for vitiligo. Presently, when a patient wants to determine how well Narrow Band UVB (NBUVB) may work for their vitiligo they are given the statistic that is often not intuitive. For example, "Ms Smith, Narrow band phototherapy will bring back approximately 75% of the skin color in 20% of patients over a six month period of time." This is often confusing to patients. The new VASI (vitiligo area scoring index) has been used in the first controlled trial to be published on the use of Narrow band phototherapy for vitiligo. The control in this study was the patient. One side was covered by a specially designed garment, which was known to be impervious to UVB light. This allowed our group to determine whether or not the treatment was having any effect on the condition. The patients were evaluated by a physician global evaluation, patient self-evaluation and a physician performed VASI score. The first step of the VASI is to divide the patient into various body regions such as the arms,trunk, legs, hands and feet. Then, using the assumption that a palm of the hand is equivalent to 1% of the body surface, the physician determines how much of the skin is affected by vitiligo. Then the physician determines what percent of the skin is depigmented by referring back to standardized pictures of various degree of pigmentation (see attached pictures). The research involved 22 patients who were treated for 60 sessions or six months with (NB-UVB) phototherapy. Using multilevel random effects modeling, the mean improvement due to NB-UVB was 42.9% versus 3.3% on the control side after 6 months of treatments. The effect of NB-UVB on vitiligo repigmentation was highly significant with p<0.0001. (The P value indicates how likely these results would occur by pure chance) A significant difference between NB-UVB and control became evident by 2 months of treatment (p=0.05). The attached figures show the effect of NB-UVB on the whole body and different body sites.

The VASI, if used by others, will allow patients to compare different treatment options against each other. A recently completed trial using NB-UVB for the treatment of vitiligo affecting the hands used a modified version of the VASI. We hope our patients will become familiar with this standard and use it to compare different treatment options. This work was done at the University of British Columbia under the guidance of Dr Harvey Lui.

Reference: Hamzavi I, Jain H, McLean D, Shapiro J, Zeng H, Lui H Parametric Modeling of Narrow Band UVB Phototherapy for Vitiligo with a Novel Quantitative Tool: the VASI Score Archives of Dermatology June: 140; 677-683





Estimating the Degree of Depigmentation for the VASI

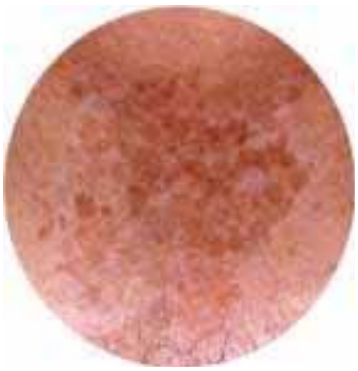
100 % Complete depigmentation

90 % Flecks of pigment

75 % Depigmentation > Pigmentation

50 % Depigmentation = Pigmentation

25 % Pigmentation > Depigmentation



10 % Flecks of depigmentation

The Excimer Laser in the Treatment of Vitiligo

Sarah Hodulik, Suhail Hadi, MD, MPhil

Vitiligo is a common disorder, characterized by patches of skin that lack pigmentation and, as a result, appear white in color. Treatment of vitiligo has proven challenging for physicians and no definite cure is currently available. Potent topical corticosteroids have been used with moderate success, but are associated with unfavorable side effects like skin atrophy, stretch marks, and visibly dilated blood vessels. Surgical treatments, such as skin grafting, melanocyte transplantation, and tissue engineering have been successful in stimulating repigmentation, but may result in notable textural changes and scarring of the skin. Oral or topical psoralens with long-wave UV radiation (PUVA) as well as broad-band and narrow-band UVB phototherapy are currently popular treatments for vitiligo. These therapies have shown moderate success rates: 51% of those undergoing PUVA treatment, 57% broad-band UVB patients, and 63% of narrow-band UVB patients achieve repigmentation. Considerable side effects, such as nausea and vomiting and also phototoxicity, are associated with PUVA treatment. Both PUVA and UVB phototherapies present a potential risk of cancer and premature aging of the skin. Additionally, in terms of patient time commitment, the treatment courses for PUVA and UVB are demanding: in order to obtain optimal results, patients generally undergo therapy several times per week for months or even years.

The excimer laser uses a medium of xenon chloride gas to generate beams of single-wave, 308 nanometer ultraviolet (UV) B light. During treatment, a series of quick pulses of UVB radiation is delivered to a small area of skin through a handheld fiberoptic piece. The excimer laser affects, at largest, a 2cm by 2cm square of the skin at one time and can be adjusted to treat smaller areas. Melanocytes are cells responsible for pigmenting the skin that are inactive or absent in vitiliginous patches. Ultraviolet B light from the excimer laser is thought either to activate dormant melanocytes in non-pigmented areas or to stimulate melanocytes located in nearby hair follicles to travel to patches of vitiligo and incite pigmentation.

Several research studies have shown the excimer laser to be a highly effective treatment for vitiligo. In a study performed at the Mount Sinai School of Medicine, Dr. James Spencer, *et al.*, demonstrated that in 6-12 treatments with the excimer laser, partial to complete repigmentation occurred in 57% of vitiligo patches undergoing therapy. A similar study done by Dr. Suhail Hadi, *et al.*, showed that up to 30 treatments with the excimer laser produced 75% or greater repigmentation in 52.8% of vitiliginous patches and 50% or greater repigmentation in 63.7% of patches. Results from a recent trial performed at Mount Sinai suggest that treatment with the excimer laser in combination with tacrolimus ointment (a topical immunomodulator) produces a greater rate of success and faster results than laser treatment alone. Results from several studies demonstrate that patches of vitiligo on the face, neck, and trunk are significantly more responsive to laser treatment than those on the hands, wrists, feet, and ankles.

These studies also suggest that treatment with the excimer laser is more efficient and probably safer than other phototherapies. Because the excimer laser delivers a higher dose of UVB radiation to vitiliginous areas than conventional phototherapy, the length of treatment necessary to achieve positive results with the excimer laser is significantly shorter than the treatment period for standard UVB phototherapy. The excimer laser targets specific patches so that skin unaffected by vitiligo is not treated during laser therapy. The result is less cumulative UVB radiation and a potential decrease in the risk of developing skin cancer compared to the risk associated with conventional phototherapy. While these are clear benefits of the precision of the excimer laser, it should be noted that this method is limited to the treatment of relatively small patches of vitiliginous skin. Overall, in addition to being a very efficacious therapy for vitiligo, the excimer laser is the fastest and likely the least hazardous treatment currently available.

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Dr. Le Poole Begins New Vitiligo Study

By I. Caroline Le Poole

"I would like to take the opportunity to invite anyone to tell me their story and/or to offer their participation in our research," said Dr. Le Poole

At Loyola University Chicago, we are trying to find out what triggers vitiligo. We know that there are hereditary factors involved. We also know that in patients with generalized vitiligo, it can be considered an autoimmune disease. What remains poorly understood is why vitiligo develops when it does. You can go for years without any white spots, and suddenly the loss of pigment sets in. Frequently, patients have told us they had either come back from a sunny vacation, or they had cut or wounded their skin in an accident, or they had been exposed to certain chemicals in the workplace prior to developing white skin patches. Others will tell us that a particularly traumatic event took place before their vitiligo developed (loss of a job, loss of a loved one). We are trying to understand how stressful conditions can lead to a loss of skin pigmentation.

In collaboration with Dr. Boissy's lab in Cincinnati, we have focused primarily on a chemical known to cause vitiligo in individuals who are sensitive to this compound. This bleaching phenol called 4-tertiary butyl phenol (4-TBP) was already known to suppress pigment formation. At higher concentrations, it can kill pigment cells as well. We found that when pigment cells are exposed to 4-TBP, they defend themselves by making what we call 'stress proteins'. These stress proteins, besides protecting the cells livelihood, can also tell the body that there is 'something wrong'. When cells release stress proteins (for example when the cell dies), the stress proteins can activate an immune response. We have shown that a key player in every immune response, the dendritic cell, is activated by stress proteins and gains the ability to kill pigment cells that are under stress. This process by itself can contribute to loss of pigment from the skin. Dendritic cells are also the 'messenger cells' of the immune response and can recruit other cells of the immune system to the site. We know for example that T cells can be found in the skin close to remaining pigment cells, but this happens only when the skin is losing pigment. We are trying to define how these T cells specifically recognize pigment cells, leaving all surrounding cell types alone. We are also interested in defining how important the stress proteins are in perpetuating this process and whether there are ways to intervene so that the immune response to pigment cells can be halted and the loss of skin pigment will stop. For our ongoing studies, it is very important that you are and have been willing to donate your time, your blood and skin tissue. I would like to take the opportunity to invite anyone to tell me their story and/or to offer their participation in our research. I will send you a short questionnaire to fill out and if you live in the Chicago area, we would be very happy to receive your tissue donation. Please contact me at ilepool@lumc.edu for further information. In the meantime, thank you for your continued support of our research.

From the Director

Anna with two of her "babies" Mo and Pappy .

Dear Friends:

I am excited and honored to be the new director for the National Vitiligo Foundation. I came on board August 9th.

I've spoken with and emailed many patients and families of patients — from all over the world. Please be patient with me as I continue to learn about this frustrating, stressful disease.

We are in the process of updating our website — especially our physician page, producing new pamphlets, and providing faster service.

Thank you for your continued support as we journey through our reorganization process.

Please let me know of ways we can better serve you and additional information or services we can provide.

Striving and Hoping Together,

Anna K. Hayes
Director

Pet Therapy — Wanted: Good Home in Exchange for Unconditional Love

This is Scarlet and she needs a home. Her human parents were killed in a plane crash so she is an orphan. It seems she has been rejected because she has vitiligo (Sound familiar?). Scarlet is a 5-year-old very gentle, Rotweiler-mix who weighs about 55-pounds and stands about 30-inches tall at her shoulders. If you can provide a loving home for her please contact Dr. Lorie Gottwald at (419) 383-3720 or email her at lgottwald@mco.edu. Travel expenses will be provided. We just want her to have a loving family!

Please take me home.

Cosmetic and Concealers Contact Numbers

The following is a partial list of products that vitiligo patients have found helpful:

Beautipharm, Inc./Biocosmetics	1-888-345-1950
Covermark Cosmetics	1-800-524-1120
Dermablend	1-877-900-6700
Dormer Laboratories	1-416-242-6167
Estee Lauder Companies	1-877-311-3883
Kirsch Cosmetic Clinic	1-877-4-KIRSCH
Safe Tan	1-800-572-3382
Summer Labs, Inc.	1-800-533-7546
Valeant Pharmaceutical (formerly ICN)	1-800-321-4576

How to Get PCAT

Your doctor's office can fax your pseudocatalase prescription to the Columbia Pharmacy at 312-791-3391 or you may mail the prescription to: Columbia Pharmacy Inc, 2929 S Ellis Ave, Chicago, IL, 60616. PCAT cannot be shipped outside the US.

Their phone number is (312) 791-3334 and their email is columbiapharmacy@aol. The price is $50 for a 15oz pump jar and $35 for a 7.5oz tube. Shipping and handling usually runs from $12-16 depending on distance from Chicago. Include the following when ordering: Name of patient / Mailing address / Patient's date of birth / Any allergies to medications / Daytime phone number / Credit card number, expiration date, and cardholder's name.

Vitiligo Bulletin

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www.nvfi.org
Email: info@nvfi.org

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Pen Pal News

If your are a parent of a child with vitiligo, please contact the Children's Hope & Dreams-Wish Fulfillment Foundation and request a Pen Pal for your child. This is a wonderful organization that matches children with chronic diseases such as vitiligo.

Pen Pal participation can be fun, educational and comforting! The Children's Hope & Dreams-Wish Fulfillment Foundation has more than 12,000 children participating in their program. You may contact them at:

Children's Hope & Dreams-Wish Fulfillment Foundation
280 Route 46
Dover NJ 07801

Phone: 973-361-7366

Fax: 908-459-9399

Email: info@chdfdover.org

NVF Gifts

Trinity Mother Frances Hospital Foundation

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Nancy and Tom Egerer

Cindy L. and Jonathon G. Stock

Camden E. Greene Foundation

Special thanks to all employees who contribute through United Way and American Charities as well as our Sustaining, Patron and Contributing Members.

How You Can Help the National Vitiligo Foundation

- Donations of checks can be made payable to the National Vitiligo Foundation (NVF)
- Donations in lieu of special-occasion gifts (especially during the December holidays)
- Donations by way of government CFC payroll deductions
- Donations of frequent flyer miles
- Donations made through your company's matching gift program
- Donations of regular planned gifts or once-in-a-lifetime gifts
- Donations by way of wills and bequest
- Donations by way of making NVF the beneficiary of a life insurance policy
- Donations from a fund-raising event

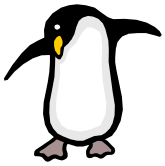
The strength of the National Vitiligo Foundation is seen in the spirit of those who care. Contact the NVF office for information on any of these options for giving.

Goals of the NVF

* To raise public and physician awareness about vitiligo and the dermatological and psychological impact on those affected by it
* To provide useful information and support to those affected by vitiligo and their families
* To support investigation into the causes and treatment of vitiligo by generating funds from individuals, businesses and organizations
* To encourage governmental agencies like the NIH to make research on vitiligo a high priority
* To identify physicians and investigators who have a strong interest in vitiligo and related disorders and assist them in obtaining support for their clinical and basic science research
* To improve the care of patients with vitiligo by providing dermatologists, other physicians and their staffs with the best available information about vitiligo and its treatment
* To embody the highest ethical and professional standards of conduct in all activities, including solicitation and distribution of funds used for research, patient support and related activities

Mission Statement

The National Vitiligo Foundation (NVF) is the world center for those with vitiligo. The Foundation strives to locate, inform, and counsel vitiligo patients and their families; to increase public awareness and concern for the vitiligo patient; to broaden the concern for the patient within the medical community; to encourage, promote and fund increased scientific and clinical research on the cause, treatment and ultimate cure.



Membership is Vital

When supporting the NVF, we ask that you give whatever amount you can. A $40.00 contribution is recommended. We ask that North American members add $10 and other members add $20 if you want to receive the newsletter by mail. More will help fund research grants. **Visa © and MasterCard © are available for your donation.**

In your will remember

National

Vitiligo

Foundation

700 Olympic Plaza Circle, Suite 404 Tyler, Texas 75701