A 16-year-old girl presented with gradually increasing hair loss and thinning. She had noticed thinning all over her scalp, with visible areas of complete hair loss along the hairline at the temples and back of the scalp during the previous year. There was an associated itchiness of her scalp. She had no personal history of autoimmune disease, however, she did have a family history of vitiligo.

On examination there was diffuse hair thinning, and patches of non-scarring hair loss at the vertex and also in the temporal and occipital areas (see Figures 1 and 2). Exclamation mark hairs were seen on dermoscopy. Blood tests demonstrated normal thyroid function and a negative antinuclear antibody result. At this stage the working diagnosis was alopecia areata, with the possible differential diagnoses being telogen effluvium or lichen planopilaris.

The patient was prescribed a trial of clobetasol propionate 0.05 per cent shampoo (Etrivex), which gave limited benefit initially with some benefit after a month.

In order to help determine the diagnosis, diagnostic punch biopsies were organised at the anterior and posterior portions of the scalp. These both demonstrated a patchy mild lymphocytic inflammation involving the hair follicles, with involution of the hair bulb. These findings strongly supported the diagnosis of alopecia areata.

The diagnosis and possible prognoses of alopecia were explained to the patient, and she was provided with written information, including the contact details for an alopecia support group.

At four months from her initial presentation, the patient had continued to use clobetasol propionate 0.05 per cent shampoo and had noticed some regrowth on the vertex of her scalp, although anteriorly there was still hair loss. The patient was prescribed clobetasol propionate 0.05 per cent (Dermovate Scalp Application; unlicensed) to apply once daily at night and wash off the next morning. This seemed to encourage further hair regrowth and the patient continued with it on an intermittent basis. At eight months from her initial presentation, the hair was much thicker, with only a small patch of hair loss at the vertex. Future management strategies were clobetasol propionate...
Alopecia areata

Prescriber 19 November 2014

Table 1. Management of alopecia areata (NICE)6

<table>
<thead>
<tr>
<th>Clinical description</th>
<th>Advice</th>
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<tbody>
<tr>
<td>Patient with spontaneous hair regrowth</td>
<td>avoid treating the patient with pharmacological therapies; the patient can be followed up to see how their condition is progressing</td>
</tr>
<tr>
<td>No clinical hair regrowth with &lt;50% hair loss</td>
<td>offer the choice of watchful waiting, avoiding treatment</td>
</tr>
<tr>
<td>No clinical hair regrowth with &gt;50% hair loss/treatment desired</td>
<td>patients should have the option of being referred to a dermatologist in the interim for those patients who have a certain diagnosis of alopecia who are adults (not pregnant) NICE suggests: 3-month trial of one potent topical corticosteroid such as: • betamethasone valerate 0.1% • fluocinolone acetonide 0.025% • hydrocortisone butyrat 0.1% or alternatively a very potent corticosteroid for three months: • clobetasol propionate 0.05% scalp application NB: these agents should not be used on facial areas such as the beard and eyebrows discuss with a dermatologist before starting treatment in children or pregnant or breastfeeding women please check the BNF prior to prescribing these medications</td>
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0.05 per cent for three-month bursts, tacrolimus (Protopic) 0.1 per cent ointment to be added in once daily for stubborn areas, and for consideration of intralesional triamcinolone if the alopecia worsened. She was given open follow-up.

Alopecia areata is considered to be an autoimmune disease and is characterised by chronic inflammation of the hair follicles. It presents with non-scarring hair loss with exclamation mark hairs (due to follicular destruction by lymphocytes). Some patients also have associated nail pitting. Alopecia areata affects 0.15 per cent of the population and the lifetime risk has been predicted to be 1.7 per cent. It is a condition mostly confined to the young, with up to 47 per cent of cases presenting prior to the age of 20 and 84 per cent prior to the age of 40.

The prognosis is variable, however, those presenting with extensive disease or as children have been shown to have a poorer prognosis. Most people will relapse at some stage. Some patients will progress to have alopecia areata totalis (whole scalp) and alopecia areata universalis (whole body).

There are several other causes of patchy hair loss. These include: telogen effluvium, trichotillomania, lupus erythematosus and linae capitis. The diagnosis of alopecia areata is clinical and investigations are unnecessary unless there is diagnostic uncertainty. In these cases a diagnostic biopsy may be helpful, or if fungal disease is suspected a fungal culture of plucked hair and scalp.

There are no treatments shown to alter the course of the disease, although some treatments, such as potent topical steroids or intralesional steroids can induce temporary regrowth. Patients should be offered counselling and psychological support, as quality of life is typically severely affected, as may be expected by this dramatically visible condition in a generally young patient group.

NICE has guidance on the management of alopecia areata (see Table 1). Patients who have hair regrowth at presentation should avoid pharmacological treatment, likewise, those with patchy loss of <50 per cent of their hair could be managed by watchful waiting. Patients with more extensive disease should be offered a referral to dermatology but can be managed in primary care during the interim or if the patient declines a secondary care referral. In these patients a trial for three months of a potent or very potent topical steroid is recommended.

Further treatments available in secondary care include: intralesional corticosteroids such as triamcinolone (Adcortyl; for limited hair loss), systemic corticosteroids, topical minoxidil, and topical immunotherapy (more extensive hair loss). Patients with extensive alopecia, alopecia areata totalis or universalis will require a specialist referral if they require a wig.

It is important to warn patients that pharmacological agents will take time to work but they might not be effective. Patients should also be advised that regrowing hair might also be white and finer than normal. Those with large areas of hair loss should be counselled about sun exposure and advised to use high SPF sun cream.

References

Dr William Hunt is an FY2 doctor and Dr Emily McGrath is consultant dermatologist at the Royal Devon and Exeter Hospital

Readers are invited to send in similar interesting case histories to Prescriber, Wiley Interface Ltd, The Atrium, Southern Gate, Chichester, West Sussex PO19 8SQ, or e-mail prescriber@wiley.com. We pay £85 for those we publish.