PATCHY AND SCARRING HAIR LOSS

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Patchy hair loss

- Are they all the same?
- Is there any way to tell the difference?
- Do they require treatment?
- Is there any treatment?
- Is the treatment the same for all?
- Is there any urgency to see a doctor?

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ALOPECIA AREATA

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Pathogenesis

- Organ-specific autoimmune disease
  - Melanocyte peptides are suspect antigens
  - Involvement of T-lymphocytes
- Genetic
  - Concordance rate of 55% in identical twins

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Clinical features

- Round or oval patches of non-scarring hair loss
- Short ‘exclamation mark’ hairs
- Alopecia totalis
- Alopecia universalis
- Ophiasis
- Nail changes- pitting

Treatment

- Topical or intralesional corticosteroids
- 5% minoxidil
- Topical immunotherapy
  - Diphencyprone (DCP)
  - Squaric acid dibutyl ester (SADBE)
  - Anthralin
- PUVA
- Systemic corticosteroids
- Systemic cyclosporine/MTX

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OTHER PATCHY HAIR LOSS

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Lichen planopilaris

- Women > men
- Patchy hair loss with perifollicular erythema, follicular spines & scarring
- Multifocal patches with central distribution common
- Up to 50% have skin, mucous membrane or nail changes associated with lichen planus

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Treatment

- Topical or intralesional corticosteroids
- Systemic corticosteroids
- Antimalarials
- Cyclosporine, systemic retinoids, MTX

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Discoid lupus erythematosus

- More common in adult females
- Typically erythematous, indurated and scaly plaques
- May be atrophic
- Can be tender or itchy

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Treatment

- Topicals or intralesional corticosteroids
- Systemic corticosteroids
- Anti-malarials
- Retinoids
- Dapsone
- Thalidomde

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Classic pseudopelade

- Non-inflammatory, intermittently progressive scarring alopecia
- Unknown origin
- Characterized by multifocal, asymptomatic, flesh-coloured patches of cicatricial alopecia
- Typical lesions start at crown & spread in ‘pseudopod-like’ fashion
- Pale depressed areas- ‘footprints in the snow’

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Treatment

- Potent topical corticosteroids
- Hydroxychloroquine
- Thalidomide
- Surgery

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Folliculitis decalvans

- Recurrent, patchy, painful folliculitis of scalp
- Scarring & subsequent hair loss
- Tufting of hairs seen
- Aetiology unknown
- Postulated abnormal host response to toxins from *S. aureus*

Treatment

- Oral and/or topical antibiotics
- Zinc
- Dapsone
- Isotretinoin
- Surgery

Dissecting cellulitis

- Uncommon chronic suppurative disorder
- Predominantly affects men from 2nd to 4th decades
- Multiple painful inflammatory nodules & fluctuant abscesses of the scalp, connected via sinus tracts
- Vertex & occiput most common sites
- Follicular hyperkeratosis thought to play primary role in pathogenesis

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Treatment

- Oral isotretinoin
- Intralesional corticosteroids
- Oral antibiotics
- Surgical approaches
  - Incision & drainage
  - Excision with grafting

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Folliculitis keloidalis nuchae

- Typically affects young adult men
- Early lesions appear as red firm papules, usually on lower occiput
- Become large hypertrophic scars
- Hair follicles & shafts become trapped in connective tissue resulting in foreign body reaction, sinus tract formation & bacterial superinfection

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Treatment

- Intralesional corticosteroids
- Topical & oral antibiotics
- Surgical excision
- CO2 laser excision
- Isotretinoin
- Cyclosporin

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Causes of patchy hair loss

Non-scarring

- Alopecia areata
- Trichotillomania

Scarring

- Lichen planopilaris
- Discoid lupus erythematosus
- Classic pseudopelade
- Folliculitis decalvans
- Dissecting cellulitis
- Folliculitis keloidalis nuchae

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Is it important to differentiate?

YES

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Why?

- Apart from alopecia areata, all the rest are scarring alopecia
- Hair loss is PERMANENT!
- Early treatment important to prevent further hair loss

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Answers

- Are they all the same? NO
- Is there any way to tell the difference? YES
- Do they require treatment? YES
- Is there any treatment? YES
- Is the treatment the same for all? NO
- Is there any urgency to see a doctor? YES

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THANK YOU

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SKIN, HAIR, PIGMENT & LASER SPECIALISTS