



Alopecia: Kids are not just little people

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Abstract Alopecia is a disorder that affects all patients, young and old. Many diagnoses, particularly the scarring alopecias, are more common in adults; however, others, such as tinea capitis, are more common in children, and some, such as alopecia areata, often affect both age groups. The approach to, and evaluation of, an alopecia patient is thus highly dependent on his or her age. In adults with diffuse, non-scarring hair loss, a part-width examination can help detect pattern hair loss, the most common cause of diffuse loss in this age group. In children this is much less likely, and a careful evaluation for tinea capitis is in order. The same holds true for patchy alopecia in children, as well as scarring alopecia—tinea needs to always be considered. In adults, patchy alopecia is often due to alopecia areata and sometimes to one of the primary scarring alopecias. A laboratory evaluation, and especially a biopsy, would be a more appropriate undertaking for an adult than a child, and an adult would be more likely to tolerate certain therapeutic regimens such as intralesional injections. In a conversational manner, the authors discuss their individual approaches to the alopecia patient, highlighting the differences in diagnosis, workup, and management that depend on whether the affected individual is an adult or a child.

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What is your approach to the diagnosis of diffuse, non-scarring alopecia in adults versus children?

LJG: The most common cause of non-scarring hair loss in adults is patterned hair loss, also called androgenetic alopecia. The major differential diagnoses are telogen effluvium and diffuse alopecia areata (alopecia areata incognita). Female pattern hair loss is a genetic susceptibility of certain follicles to androgens. Affected follicles become smaller (miniaturize) with successive hair cycles, and the hair

cycle shortens. An acute telogen effluvium follows a physical or emotional event, and the hair cycle becomes synchronized causing noticeable shedding and at times diffuse thinning. It is self limited, although a chronic form has been described which can last several years.¹ Diffuse alopecia areata is an autoimmune disease that causes diffuse hair loss rather than classic patches. It is often confused with a telogen effluvium at first, but soon the amount of hair lost becomes more severe than would be expected in a telogen effluvium (Figure 1).

When an adult patient complains of hair loss, I first try to sort out if the patient has hair shedding, or if the patient just notices a decrease in volume. Female pattern hair loss, telogen effluvium, and alopecia areata can cause shedding, but if there is no shedding a telogen effluvium is unlikely. A

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Fig. 1 Photograph of diffuse alopecia areata on the crown resembling female pattern hair loss.

careful history and physical examination can go a long way into distinguishing between these entities. Important items in the history are the presence or absence of shedding, a precipitating event or medication change, past medical history including anemia, gastrointestinal, thyroid, or autoimmune disease, a history of eating disorders or dietary restrictions, a medication history, and, in women, a menstrual history. The examination should focus on whether there is a pattern to the hair loss, which in men would be the temples, crown, and/or vertex, and in women the crown and sometimes the temples.² The easiest way to do this is to do a part-width assessment. This involves parting the hair on the occiput to get a sense of the patients' baseline, and comparing it to the part on the crown. A wider part on the crown indicates female pattern hair loss (Figure 2), especially if it is widened more anteriorly than posteriorly (said to resemble a Christmas tree). In my experience, hair loss on the



Fig. 2 Photograph of a widened part in female pattern alopecia resembling a Christmas tree.

temples with small, short hairs replacing terminal hairs could be either a resolving telogen effluvium, in which case the hairs should get longer over time, or female pattern hair loss, in which case they will persist or miniaturize further. Sometimes, measuring the length of these hairs over time is useful. Diffuse alopecia areata causes rather abrupt, moderate to severe hair loss. A biopsy may be helpful, if this is suspected.

Trichoscopy, or dermatoscopy of the scalp, can be helpful to the experienced user, and criteria have been set that distinguish pattern hair loss from telogen effluvium.³ One can see variation in hair shaft diameter in pattern alopecia, whereas hair shaft diameter is normal in a telogen effluvium. Dermatoscopy may be helpful to find black dots or exclamation point hairs in alopecia areata.⁴

LACS: In contrast to adults, the most common cause of non-scarring hair loss in children is tinea capitis. Tinea capitis can present with diffuse hair thinning, usually with some scale or more localized patchy hair loss and sometimes with no inflammation but with broken hairs.^{5,6} The major differential diagnosis, though, includes many of the same entities seen in adults and does include telogen effluvium and diffuse alopecia areata/totalis/universalis spectrum. It is uncommon for children to have androgenetic alopecia, though this entity can be seen in teenagers and occasionally even school-aged girls. History of familial female and male pattern in androgenetic alopecia usually is present in these children.⁷ Because genetic syndromes can present with poor growing or sparse hair, ectodermal dysplasias and primary genodermatoses should also be considered in any new evaluation of thin hair/sparse hair in children.⁸

The cause of hair loss can usually be teased out with a combination of good history and thorough hair, scalp, and nail physical examination. Good history taking includes past medical history with particular attention to autoimmune disease and nutritional deficiency, medications, recent illness, timing of the hair loss, presence or absence of shedding, and whether any contacts have similar hair loss. The examination of the scalp is systematic and should note patterns of hair loss such as primary loss at vertex, parietal, and occipital scalp. Scalp examination should also note scale and redness. Dermatoscopy in children provides many clues to non-scarring alopecia. The presence of comma-shaped hairs and corkscrew hairs can be seen in tinea capitis. Yellow and black dots as well as exclamation point hairs are often seen with autoimmune alopecia.^{9,10}

Tinea capitis typically affects school-age children and is more common in children with tight, coarse, curly hair but can be seen in all ethnicities and in both genders. Most children present with some redness, scaling, and have cervical lymphadenopathy (Figure 3). Many, but not all, have had exposure to another child with tinea capitis.⁶ The definitive test is a dermatophyte screen. This test helps type the variety of tinea, which sometimes guides the choice of antifungal systemic medication, but often hyphae can be seen on potassium hydroxide preparation alone. Very extensive tinea capitis can lead to a severe inflammatory response in

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