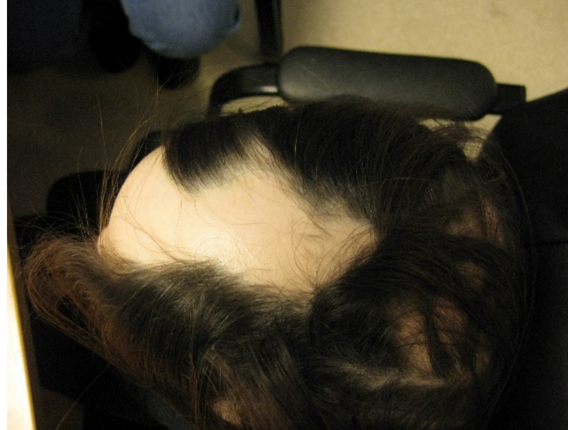
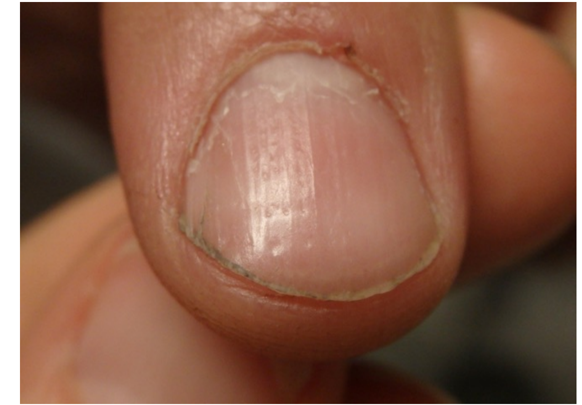
Alopecia Areata

Background

- T-cell driven autoimmune disorder
- Cause unknown
- Hypothesized that in genetically susceptible individuals, loss of immune privilege of the hair follicle allows for T-cell inflammation against anagen hairs and follicles, leading to arrest of hair growth



Alopecia areata



AA associated nail pits

Presentation

- Non-scarring, rapid hair loss, exclamation point hairs
  - Patchy: hair loss in round or oval patches
  - Totalis: entire scalp involved
  - Universalis: all body hair involved
- 10-15% have nail involvement

Associated Conditions

- Auto-immune conditions:

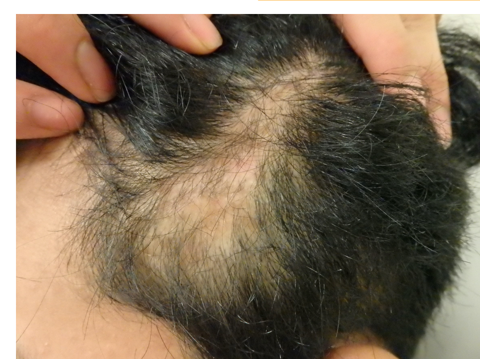
  Hashimoto thyroiditis, Addison disease, pernicious anemia, ulcerative colitis, myasthenia gravis, collagen vascular diseases, vitiligo
- 10-15% of patients with Down syndrome

Treatments

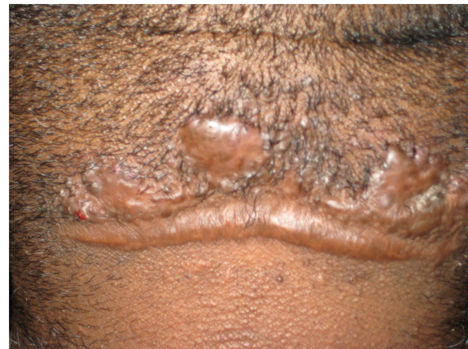
- Anticipatory guidance: course is unpredictable, often spontaneous resolution in 6-12 months, but recurrences are common.
- Local therapy: high potency topical corticosteroids daily 3 weeks on 1 week off; intradermal injections of steroid (triamcinolone 2.5 mg/ mL) every 4-6 wk; minoxidil OTC; anthralin; contact sensitization.
- Systemic: pulse corticosteroids (although side effects a concern for long term use) or a steroid sparing immunosuppressant such as methotrexate, JAK inhibitor.

Alopecia DDx:

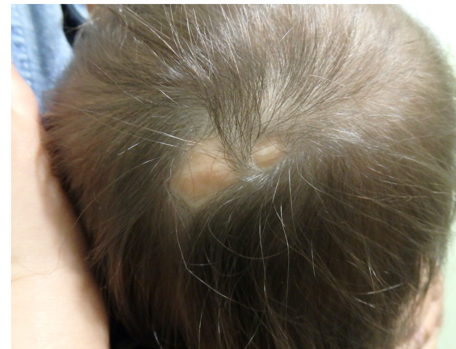
	Scarring (less common)	Non-scarring (common)
Localized	Some kerion (2nd to tinea capitis) Acne keloidalis Discoid lupus Central centrifugal cicatricial alopecia Lichen planopilaris (LLP) Folliculitis decalvans Frontal fibrosis Morphea Aplasia cutis	Alopecia areata Tinea capitis Traction alopecia Trichotillomania Triangular temporal alopecia Androgenic/patterned alopecia
Diffuse	Dissecting cellulitis	Alopecia totalis/universalis Anagen effluvium Telogen effluvium Loose anagen syndrome



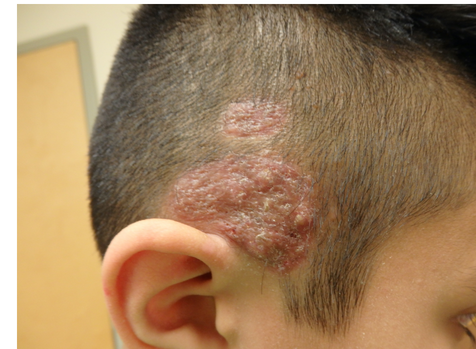
Morphea – en coup de sabre



Acne keloidalis



Aplasia cutis



Tinea capitis