Dermacase

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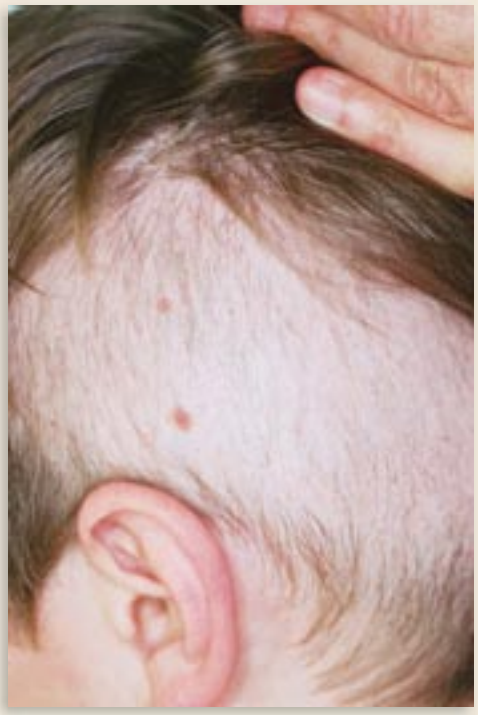

CAN YOU IDENTIFY THIS CONDITION?

A patient presents with hair loss on his scalp. The hair that remains is of unequal length and fractured.

The most likely diagnosis is:

1. Trichotillomania
2. Alopecia areata
3. Pseudopelade
4. Telogen effluvium

Answer on page 510

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1. Trichotillomania

Trichotillomania is a psychiatric disorder resulting in a characteristic hair loss pattern. Hair is lost through repetitive pulling, twisting, and rubbing. Hair loss might also be due to use of tweezers, scissors, or razors. Hair pulling with early onset (younger than age 6) is reported to end of its own accord more frequently than when it appears later in life.[1] Incidence of trichotillomania is higher among women than among men. The scalp is most frequently involved, followed by the eyebrows, eyelashes, facial hairs, and pubic and chest hairs. Patients feel a tension that is relieved by pulling out hair. Diagnosis can be complicated by patients' denial of hair pulling.

Certain clinical features differentiate trichotillomania from other hair disorders. The most distinguishable characteristic is an irregular pattern of fractured hairs of unequal length.[3] Alopecia areata appears as a nonscarring, well-defined oval area of scalp with no hair (or hair of equal length if growth has occurred) surrounded by "exclamation hairs." With trichotillomania, areas of hair loss are sharply or poorly defined, and there is no scarring. There is no inflammation at the site with either condition. In difficult cases, trichotillomania can be differentiated through histopathology.[4]

Treatment can be difficult. Patients with trichotillomania should be referred to psychiatrists. Appropriate therapies include psychotherapy, behavioural therapy, or appropriate medication.[5] The tricyclic antidepressant clomipramine has been shown to be somewhat effective, but patients' compliance is often poor. Highly selective serotoninergic receptor reuptake inhibitors (SSRIs), such as citalopram, paroxetine, and fluvoxamine, might be effective. First-line therapy includes clomipramine or SSRIs. Lithium carbonate, which decreases neuronal excitability, and naltrexone, an opiate antagonist, might also be helpful. Habit reversal training is the most effective behavioural therapy; it targets the obsessive-compulsive disorder that causes patients to tear out their hair.

References

1. Walsh KH, McDougle CJ. Trichotillomania. Presentation, etiology, diagnosis and therapy. *Am J Clin Dermatol* 2001;2(5):327-33.
2. Hautmann G, Hercogova J, Lotti T. Trichotillomania. *J Am Acad Dermatol* 2002;46(6):807-21; quiz 822-6.
3. Jackson EA. Hair disorders. *Prim Care* 2000;27(2):319-32.
4. Sams WM Jr, Lynch PJ. *Principles and practices of dermatology*. New York, NY: Churchill Livingstone; 1990. p. 770-1.
5. Odom RB, James WD, Berger TG. *Andrews' diseases of the skin. Clinical dermatology*. 9th ed. Philadelphia, Pa: W.B. Saunders Company; 2000. p. 949.