Better treatment outcomes for patients with alopecia

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In this issue of the *Journal of the American Academy of Dermatology*, Vano-Galvan et al[1] report that oral minoxidil improves background hair thickness in patients with lichen planopilaris. This study serves to remind us of a simple principle: patients with alopecia want hair, not just a single diagnosis. Many of our patients with alopecia have more than 1 diagnosis, and effective management requires therapy directed at all causes of alopecia. Pattern alopecia affects almost 50% of the adult male and female population of European descent, and the incidence increases with age.[2,3] Although the prevalence is lower in Asian patients,[4] when treating patients of European descent, expect that roughly half of those with scarring alopecia will also have pattern alopecia—treating both will lead to better outcomes.

Topical minoxidil has been used for many years to treat pattern alopecia, and recent studies have shown the effectiveness and tolerability of low-dose oral minoxidil in this setting.[5,6] Evolving data suggest that oral minoxidil may have a role in alopecia areata and scarring forms of alopecia beyond the treatment of background pattern alopecia.[6,7] My own practice patterns have evolved over the years, with higher doses of spironolactone (100 mg twice daily) in women with primary or background pattern alopecia and a lower threshold to add low-dose oral minoxidil to the treatment regimen.

Telogen effluvium often unmasks underlying forms of alopecia, including both pattern and scarring alopecia, and reversible causes such as diet and thyroid disease should be addressed as part of the overall management strategy. There is an opportunity for improved outcomes if all causes of alopecia are diagnosed and addressed. Follicular erythema, doublet hairs, and silver follicular spines suggest lichen planopilaris; crops of epilating pustules suggest folliculitis decalvans; and skin lesions in the conchal bowl suggest lupus erythematosus. Shed hairs should be examined for the presence of telogen bulbs versus the tapered fractures of diffuse alopecia areata, and a biopsy read by a dermatopathologist skilled in the diagnosis of alopecia can be valuable in directing appropriate therapy.

Few dermatologists feel a thrill of anticipation when a patient mentions alopecia. A comprehensive treatment approach has the potential to improve outcomes and make us better physicians. We are experts at clinical diagnosis and can apply those skills to hair disorders. Gelatin foam stuffed into the biopsy site rapidly stops even arteriolar bleeding and takes the stress out of scalp biopsies. Don't fear alopecia. Learn how to perform a comprehensive evaluation and treat it more effectively.

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