Reply to: "Racial characteristics of alopecia areata in the United States"

To the Editor: We were quite interested in the work put forth by Lee et al[1] pertaining to the association of race and ethnicity with alopecia areata (AA). Using National Alopecia Areata Registry data, they showed that African Americans had greater odds of having AA, while Latino individuals demonstrated no difference in the risk of AA development when compared with White individuals. These findings were also consistent when controlled for age and sex. A previous cross-sectional analysis by the Nurses' Health Studies I and II found that Latina women had a greater lifetime incidence of AA when compared to non-Latina White women.[2]

We aimed to use data from the 2007-2016 National Ambulatory Medical Care Survey database to detect racial or ethnic health disparities in AA. We limited our analysis to dermatology visits in which visits for AA were compared to visits for other dermatologic conditions. In this analysis, we identified 14,400 visits, which estimated to 329 million visits. A χ^2 analysis (Table I) endorsed the findings of a study by Thompson et al[2] by demonstrating higher proportions of AA visits by Latinos and non-White individuals. Bivariate analysis showed the increased likelihood of Latino individuals visiting for AA compared to non-Latinos (odds ratio 2.5; 95% confidence interval 1.1-5.6; $P = .03$) and of non-White individuals when compared to White individuals (odds ratio 2.4; 95% confidence interval 1.2-5.1; $P = .02$). Although Lee et al[1] detected a decreased likelihood of AA among Asian individuals, our analysis did not identify significant differences in AA visits by Asian individuals when compared to those by White individuals (odds ratio 1.6; 95% confidence interval 0.38-6.7; $P = .5$). Multivariate analysis was limited by the small sample size of AA visits; however, differences in race and ethnicity in individuals seeking care for AA were appreciated in the bivariate analyses.

Our findings corroborated the increased likelihood of AA visits by Black individuals in the National Ambulatory Medical Care Survey database, suggesting that Black individuals were more likely to seek care or have more severe disease. However, we did find that Latinos were also more likely to be diagnosed with AA by a dermatologist. A recent PubMed search using the terms "alopecia areata" and "Latino" or "Hispanic" yielded only 4 publications. Since the referenced study was published, there have been no other studies addressing health disparities in AA particularly among Latino patients. With the growing Latino population reaching 18.5% in the United States,[3] we identified a need for AA studies assessing the role of ethnicity in biologic predisposition, environmental contribution, diagnostic approaches, and treatment efficacy.

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Table I. Chi-square analysis comparing visits for alopecia areata and visits for all other dermatology visits

	Alopecia areata (in millions)	Other	Total	*P* value
N	1.8 (1.3-2.2)	327 (322-332)	329 (324-334)	<.0001
Age (median) (years)	35.2	56.7	56.6	<.0001
Sex				
Female	1.0 (0.7-1.4)	182 (177-186)	183 (178-187)	.58
Male	0.7 (0.4-1.0)	146 (142-150)	146 (142-150)	.58
Race				
Non-White	0.30 (0.09-0.50)	26.0 (24.1-28.3)	26.4 (24.4-28.3)	.02
White	1.5 (1.0-1.9)	301 (296-306)	302 (298-308)	.02
Ethnicity				
Latino	0.25 (0.06-0.43)	20.3 (18.5-22.0)	20.5 (18.7-22.3)	.02
Non-Latino	1.5 (1.1-1.9)	307 (302-312)	309 (304-314)	.02

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Conflicts of interest

Dr Gonzalez has no conflicts of interest to declare. Dr. Fleischer is a consultant for Boerhringer-Ingelheim, Incyte, Qurient, SCM Lifescience, Syneos, and Trevi and is an investigator for Galderma and Trevi.

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