Hair Loss

Hair Loss – Primary Care Treatment Pathway

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Introduction

- Hair loss is a common presentation; it can affect anyone, at any age, and can occur anywhere on the body
- Alopecia is the term for all conditions that lead to hair loss
- Alopecia is divided into two groups – **Scarring** where follicle destruction leads to permanent hair loss, and **non-scarring alopecia,** where follicles remain intact, therefore allowing for potential hair regrowth

The Hair Loss Consultation

Sensitivity may be required when taking a history

- **What have they noticed** *Where on the body is the loss?* Is the complaint of **shedding** (my hair is falling out), or **thinning** (I see more of my scalp), *Is the hair loss* ***widespread***, or ***localised****?* Is the hair loss from the *roots*, or is the hair *breaking*? *Are any* ***other areas affected?*** Is it continuous, intermittent, or a one-off? *What is the speed of loss? Has this happened before?*
- **Are there any scalp symptoms or signs** e.g. itch, pain, burning, flaking, crusting, colour change?
- **Ask about hair care.** Frequency of washing, dyeing, chemical treatments, drying and grooming, hair styles and headwear before hair loss occurred. Hair style history should include a few years before hair loss started
- Semi-/permanent **hair styles** (such as integrated systems, braids, weaves, locs) can change the presentation i.e. shedding may not be apparent
- **Occupation:** Helmets, hard-hats, headbands may contribute to excess tension and/or friction
- **Recent changes**. Are there other illnesses or recent upheavals in the recent past? Think of bereavement, anaemia, weight loss, major dietary changes, thyroid disease, PCOS, autoimmune disease, and chemotherapy
- Are there any new **medicines**, or OTC supplements?
- **Family History** – Is there any family history of hair loss?
- **Impact** – Explore the impact of hair loss
- **Explore beliefs and concerns** – This is vital
- **What have they tried?** Medications topical and oral, aesthetics treatments, supplements, herbal remedies

KEY

- AA – Alopecia areata
- CCCA – Central centrifugal cicatricial alopecia
- DLE – Discoid lupus erythematosus
- FD – Folliculitis decalvans
- FFA – Frontal fibrosing alopecia
- LPP – Lichen planopilaris

Examination Pearls

- A separate consultation may be needed
- Can be limited by hairstyle, if possible, ask to amend hair style or remove hair pieces for examination
- **Assess the pattern of hair loss:** is it localised, focal or diffuse? Assess all hair margins – are the hairlines receding? Is there a loss of the sideburns, beard or moustache? Assess loss elsewhere on the body. Any rashes over the body?
- Look at hair loss: is the skin shiny suggesting scarring?
- **Feel the areas of hair loss** (don't be afraid to touch): Does the skin feel smooth, or can you feel shortened hairs? Does the skin feel boggy? Is it red/inflamed? Are there pustules? Is there scale or crust? Is there any pigmentary change to the scalp?
- Check for any head and neck lymphadenopathy
- **Nails** can also be affected. Look for nail changes, e.g. pitting or features of skin or systemic conditions

Investigations

- **Basic investigations** include FBC, iron status (ferritin), U&Es, vitamin D and thyroid function
- **Other investigations** that may be useful include zinc, folic acid and B12 if there are dietary concerns; syphilis serology where suspected; ANA; early morning testosterone, free androgen index & SHBG
- If pustules/pus are seen, a **bacterial swab** may help
- If scale is seen, or fungus suspected, perform scrapings from the edge of scaling and hair pluckings for **mycology**
- **Dermoscopy** is invaluable for hair loss assessment. Look for the follicle openings as this will help distinguish between scarring and non-scarring alopecia
- Taking good **clinical photographs** will help for monitoring progress, record-keeping and advice-and-guidance

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Key Considerations

- Hair can have aesthetic, cultural and religious significance
- Different types of hair loss may co-exist mutually or exclusively, at any one time
- A normal scalp exam does not exclude hair loss
- **Listen** – Clinicians often underestimate impact
- **Psychosocial burden** is often underestimated by health professionals
- **Impact** of functional challenges of hair loss i.e. nasal hair (nasal dripping) or eye lashes (eye irritation)
- Be mindful of **hair styling practices**, as they can significantly impact diagnosis and management

When to Refer

- Diagnostic uncertainty
- Suspected scarring hair loss
- Extensive or progressive hair loss
- Hair loss not improving within 3-6 months in AA
- Treatment resistant hair loss
- Severe psychological distress
- Wig and hair pieces (if unable to provide in primary care)

Resources

- **Alopecia UK** – alopecia.org.uk
- **British Association of Hair Restoration Surgery** – bahrs.co.uk
- **British Hair and Nail Society** – bhns.org.uk
- **Changing Faces** – changingfaces.org.uk
- **Clinical Knowledge Summaries** – cks.nice.org.uk
- **Halo Collective** – halocollective.co.uk
- **Little Princesses Trust** – littleprincesses.org.uk
- **Macmillan Cancer Support** – macmillan.org.uk
- **NHS Hair Loss** – nhs.uk/conditions/hair-loss
- **Scarring Alopecia Foundation** – scarringalopecia.org

www.pcds.org.uk

Visit our website for more advice and images of hair loss conditions

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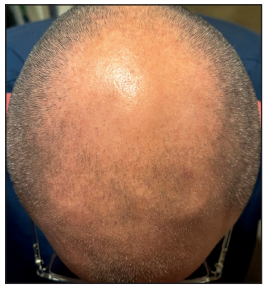
Principles of Management

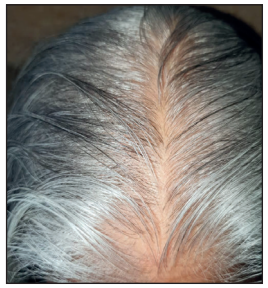
1. **Tailor management** according to patient preferences and expectations
2. **Be realistic:** manage expectations and give a reasonable timeline for hair improvement, where applicable
3. **Consider referral** to psychological services, where appropriate
4. **Optimise diet** and aim for micronutrients to be at least mid-reference range
5. **Signpost to Alopecia UK** for support & guidance on camouflage options. Cosmetics & wigs can be just as effective as active treatments

Non-scarring Alopecia – Commonest Form of Hair Loss

- **Acute Telogen Effluvium** usually presents as diffuse hair loss, 2-6 months after a significant triggering event such as fever, infection, pregnancy, emotional stress, medications and significant weight loss. It typically resolves 6-9 months after triggering event. Reversal of the trigger should lead to eventual restoration of hair density, unless there is an underlying PHL or micronutrient deficiency such as iron
- **Pattern Hair Loss (PHL)** presents as a progressive, thinning of scalp hair. In male pattern, there is thinning of the frontal hairs over the temples and crown with preservation over the occipital scalp. In female pattern, hair-parting widening or diffuse thinning is seen with preservation of the frontal hairline. PHL is not funded for treatment in primary care, but treatments may be available in secondary care (check local provision), OTC or privately
- **Alopecia Areata (AA)** is an autoimmune condition. It can be patchy, or global, such as alopecia totalis & universalis. It can arise at any age. Clinical course can be variable, and it can remit & relapse. For patchy loss, consider a trial of at least a potent topical steroid for 3-6 months, warn of side effects (skin thinning and painful scalp acne). If there is no improvement, or loss is global, rapid and progressive, refer to secondary care for consideration of intralesional steroids, contact immunotherapy, or ritlecitinib (Litfulo®). Be aware syphilis can present with patchy hair loss
- **Tinea Capitis** is a fungal infection that presents as patchy hair loss and scaling. Seen typically in children. If widespread in adults consider testing for immunosuppression (e.g. HIV). Typically, it is non-scarring but may present as a boggy inflamed mass (kerion) that if not treated promptly can cause scarring alopecia. Mycology confirmation is required, but do not delay treatment in the presence of a kerion or positive contact and treat before results are available. Oral antifungal treatment is usually required
- **Traction Alopecia (TA)** is a trauma induced alopecia caused by certain hairstyles. Chronic tension on hair leads to gradual hair loss. It often affects hair margins but can occur anywhere on the scalp. It can in some cases lead to scarring alopecia. Key management is change of practice and patient education to adopt a lower-risk hairstyle. Reference for further learning DOI: 10.1016/j.ijwd.2021.01.019



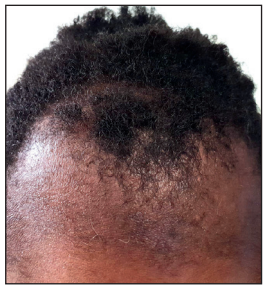
Late Male Pattern Hair Loss



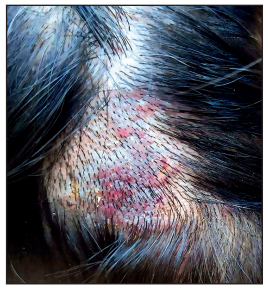
Early Female Pattern Hair Loss

Patchy AA affecting beard

Patchy AA in a patient with extensions/braids hairstyle



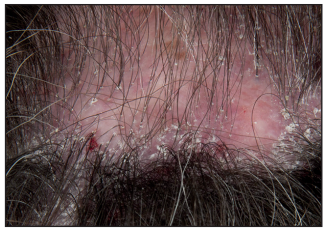
Marginal traction alopecia



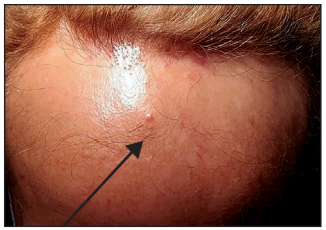
Tinea capitis

Scarring Alopecia

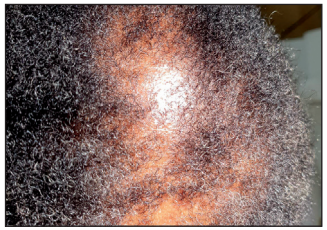
- Refer **urgently and seek advice-and-guidance** for steps that can be undertaken in Primary Care. Good images result in better advice
- The aim of treatment is to **stop further hair loss**, as follicles already destroyed cannot be salvaged
- There are **several types** (see figures): some may be associated with shiny patches of hair loss, variable inflammation or pigmentary change on the scalp, scaling, pustules, tufting of hairs, and bogginess or swelling
- Swab pustules or pus to direct antimicrobial therapy, if appropriate
- **Scarring alopecia** may be asymptomatic or present with symptoms of pain, itch, burning, or altered sensation
- **Common scarring alopecias**: LPP, CCCA, DLE, FFA, FD



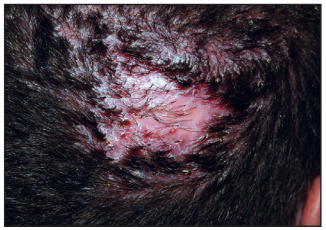
Patch of LPP – note erythema, perifollicular scale & loss of follicular ostia



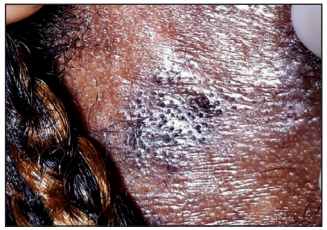
FFA – note orphan hairs and shiny appearance of forehead



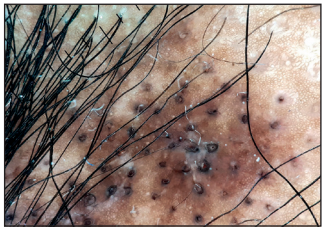
CCCA – hair loss over crown shiny appearance with loss follicular ostia



FD – note erythema, tufting, pustules and loss of follicular ostia



DLE – hyperpigmented patch and follicular keratotic plugs



DLE – Dermoscopy image of DLE patch

Special thanks to Dr Naomi Kemp for contributing images to this pathway.