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Androgenetic alopecia or fibrosing alopecia in a pattern distribution: When to perform biopsy in unusual cases?

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Full Text

Sir,

Fibrosing alopecia in a pattern distribution (FAPD) is a recently described primary cicatricial alopecia type. It closely resembles to androgenetic alopecia (AGA) clinically, but shares trichoscopic and histopathological features of AGA and lichen planopilaris.[1],[2],[3],[4],[5] AGA is a common type of non-cicatricial alopecia and is usually diagnosed clinically.[2] However, the introduction of FAPD raised the question: whether some of the patients suspected with AGA are actually affected with FAPD, and are under the threat of permanent hair loss.

In the last two months, three male patients, 34 (patient 1), 22 (patient 2), and 19 (patient 3) years of age, were presented with the complaint of hair loss, which was more pronounced on the crown. They reported gradual thinning of hair over several years, albeit an abrupt hair shedding accompanied with a very mild pruritus in the last few months. Dermatologic examination revealed diffuse hair thinning along with scaling predominantly on the vertex and frontoparietal area, bitemporal recession [Figure 1]a and [Figure 1]b; the hair-pull test was strikingly positive in all patients. Trichoscopically hair shaft diameter variability, predominance of single hair follicles, and interfollicular scales [Figure 1]c were observed in patients 1 and 2. Multiple dotted, comma, and elongated vessels were additionally noted in patient 1. Trichoscopy revealed localized loss of follicular ostia, interfollicular scales, perifollicular scales in a few scalp areas, elongated and concentric perifollicular blood vessels [Figure 1]d, and peripilar sign in patient 3. Histopathology of transverse sections of a 4-mm punch biopsy specimen obtained from the frontoparietal

scalp in all patients, showed miniaturization of terminal hair follicles, basal vacuolar degeneration affecting the isthmus and infundibulum of both miniaturized and non-miniaturized follicles, perifollicular lymphocytic inflammation, and fibrosis [Figure 2]. All patients were diagnosed with FAPD, and treated with oral hydroxychloroquine (400 mg/d), topical 5% minoxidil lotion (twice daily), and intralesional injection of triamcinolone acetonide (5 mg/mL).{Figure 1}{Figure 2}

FAPD is considered to be a T-cell-mediated autoimmune reaction affecting both terminal and vellus hairs.[3] However, whether it results from the follicular senescence resulting in a bulge immune privilege collapse and represents a particular presentation of AGA with a lichenoid follicular inflammation or it is a separate entity is unclear.[3],[4],[5] The biphasic course of FAPD with gradual thinning over several years followed by an accelerated hair loss and scalp inflammation also raises the possibility of coexistence of diffuse lichen planopilaris and AGA.[2]

Herein, perifollicular or diffuse scalp erythema which differentiates FAPD from AGA trichoscopically[2],[3] was not observed. Perifollicular scales and loss of follicular ostia, signs of FAPD,[3] were so subtle in a few scalp areas in only one patient. In addition, except a very mild pruritus, the patients did not complain about frequent scalp symptoms of FADP. Yet, interfollicular scaling was prominant and hair-pull test was strikingly positive, which is reportedly not seen in FAPD. Results of our cases suggest that abrupt onset of hair shedding in patients with pattern hair loss accompanied with scaling, which is not necessarily perifollicular, may represent an unusual clinical presentation of FAPD, and warrants performing scalp biopsy to confirm the diagnosis.

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Conflicts of interest

There are no conflicts of interest.

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