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“I’m losing my hair doctor” A Survival guide for GPs

Hair is an important component of body image. It is one of few physical characteristics we can change and manipulate to the dictates of culture and fashion. It plays a vital subliminal role in the communication of health, wellbeing, sexual attractiveness and flirtation. The visual language of advertising supports to this. Ask yourself what the photograph below communicates.

It is no surprise then, that our hair has significant emotional significance. The distress that losing it can cause is often huge, particularly for women but also (in a less acknowledged way) for men too.

For Doctors, hair loss can sometimes be a heart sink problem. There is a perception that the issue is cosmetic and that little treatment is available. In short consultations it can be difficult to give patients with hair loss time to express their feelings and work towards a differential.

As a result patients can feel their problem has been dismissed and leave their appointment feeling foolish, depressed or angry.

Avoiding patient’s disappointment is easy. It only requires a methodical diagnostic approach and an awareness of the broad strokes of the differential diagnoses.

History

1. Always acknowledge how distressing the problem is. Validate the patient's concern. Often patients have been dismissed in the past or told by friends and family that they "can't see a problem with their hair" or that "they have great hair". For most people the fear of going bald is what has prompted their trip to the doctor that fear has to be taken seriously even if it seems unlikely their fear will ever become a reality.

2. Check if the hair is coming out at the roots or breaking. If the hair is breaking this may suggest a problem with a cosmetic treatment, tinea capitis trichotillomania or a genetic hair shaft abnormality like Netherton's syndrome or trichorrhexis nodosa.

3. Ask the patient if their problem is predominantly shedding or thinning. Dramatic shedding may suggest a telogen effluvium; thinning is more likely to indicate androgentic alopecia. Some patients will even bring in hair in bags to show you. You should examine these with interest even thought they may not help with the diagnosis.

4. A good way of gauging the severity of hair loss is to ask patients if they find they need to use more loops on their hair tie than before. This allows the doctor to gauge the severity of the hair loss. Patients with thick hair can easily lose up to 50% of ponytail volume without it becoming visible on the scalp. It is for this reason that sometimes doctors (some would say understandably!) don't believe patients have a serious problem even if they report dramatic shedding.

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5. Ask about diet. Vegans and vegetarians may lack iron and protein in their diet. The lack of protein or iron can be causes of diffuse alopecia. Crash diets often cause a telogen effluvium. A lot of patients will ask you about the role of zinc, biotin, niacin, vitamins C and D, copper, and other supplements. Well nourished patients almost always have normal levels of these and there is no evidence that supplementing them above normal levels is of benefit. However, replacing iron is sensible: aiming for a ferritin of 70 mg/L. Anabolic steroids can induce male pattern hair loss.

6. Ask about menstrual cycle and contraception. Irregular periods can indicate polycystic ovaries so it can be worth asking about acne and hirsutism too. Stopping the OCP often leads to a delayed telogen effluvium as is often seen after pregnancy. Heavy periods are frequently associated with mild anaemia.

7. Family history. This is often present in men and women with androgenic alopecia and present in 10% of patients with alopecia areata. Scarring alopecias are less commonly heritable.

8. Ask about styling. Braids and tight ponytails can produce bizarre patterns of alopecia in traction alopecia.

Examination

1. Assess the scalp with good light, dermatoscope (if available) and a comb.

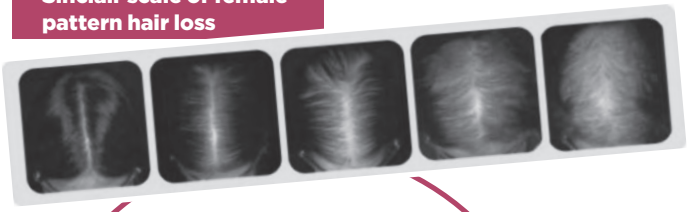
2. Is the hair loss patchy or diffuse? If the hair loss is diffuse, is the frontal hairline preserved or is there frontotemporal recession? Female pattern hair loss often has a preserved frontal hair line and a positive "Christmas tree sign" on centre parting. In Telogen effluvium patients often there is tufty short hair at both temples. Patients with hair loss secondary to syphilis can have a characteristic "moth eaten" appearance.

3. If the hair loss is patchy is it scarring or non scarring? If the patch of loss looks shiny and the follicular openings are nowhere to be seen it is likely to be scarring. Patchy hair loss with scarring needs a biopsy. Signs of Lupus and Lichen planus should be looked for: does the patient have pink scarring with telangiectasia or do they have perifollicular scale with a more glassy sarred appearance? Some patients might have signs of sarcoidosis (like lupus pernio and dactylitis) or features of scleroderma (like morphoea en coup de sabre).

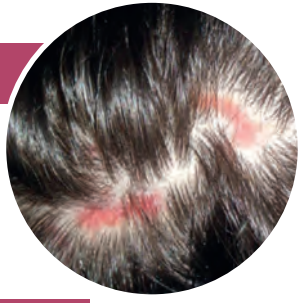
If the patches still have normal skin with intact follicular openings, look for the exclamation mark hairs and black dots of alopecia areata. If you have a deratoscope yellow dots may be visible. If the patch is scaly it is worth taking a scraping or brushing for fungal microscopy and culture. Sometimes it is worth examining the patient with a woods (UV) lamp: Microsporum canis glows bright green under UV light!

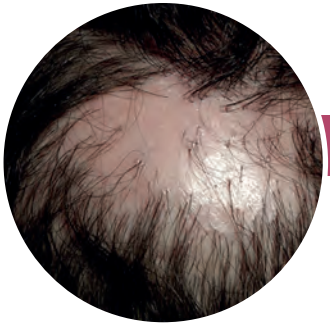
4. Perform a "hair pull test". This means taking 30 or so hairs in a pinch between finger and thumb and gently pulling them. More than 5 hairs represent a positive result. Patients with telogen effluvium and alopecia areata often have positive hair pull tests whereas androgenetic alopecia is often negative. False negatives often occur if the patient has washed their hair. The hairs pulled out should be examined with a dermatoscope. In scarring alopecias a positive hair pull is a sign of disease activity.

Sinclair scale of female pattern hair loss



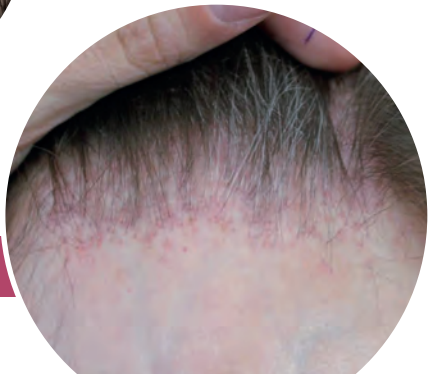
Discoid Lupus Erythematosus





Lichen Planopilaris

Hamilton-Norwood scale of male pattern hair loss



Frontal Fibrosing Alopecia

INVESTIGATIONS

Huge lists of blood tests are often requested for scalp patients. This is not always necessary. Most male pattern hair loss patients won't require bloods. Females with diffuse alopecia should have a routine blood screen.

In some patients syphilis serology may be appropriate. Zinc is often requested but is probably unnecessary in patients who are not malnourished.

Where there is concern about virilisation or hirsutism, Dehydroepiandrosterone (DHEA) and 17 hydroxyprogesterone may be useful to pick up occasional cases of adrenal tumours and Congenital Adrenal Hyperplasia respectively.

SCALP BIOPSIES

These are always indicated in cases of scarring alopecia to differentiate between different causes. Immunofluorescence can be helpful particularly in cases of Lupus where granular staining with IGG and C3 are often found on the dermoepidermal junction.

Differentiating between telogen effluvium and female pattern hair loss often requires scalp biopsies as patients with female pattern hair loss can present with initial shedding.

Your local dermatology department should help with scalp biopsies.

Summary

Always take a bit of time with these patients to acknowledge that this is a serious problem. Above all things try and identify the pattern of hair loss and check for scarring alopecia and alopecia areata. Refer patients early with some blood tests already ordered if possible. There is a lot that can be done for alopecia patients of all kinds, from areata to female pattern hair loss. Don't make the mistake of telling them there is little that can be done as often there are lots of treatments that can be tried and the results are best if the patient tries them earlier.

Hair heuristics
Validate the patient' distress. Patients are extremely distressed by losing their hair. Make sure they know you take their problem seriously.

Remember your key questions:
Do they notice shedding or thinning?
Is the hair loss patchy or diffuse?

They should have some blood tests:
A good standard screen for diffuse pattern hair loss:
- Fbc • Liver and Renal tests • Iron
- Ferritin • Vitamin d • Vitamin b12
- Folate • Ana • Thyroid function
- Treponemal serology (if appropriate)
- Free serum testosterone
- Sex hormone binding globulin
- Lh/fsh • Prolactin (if not on OCP)

If signs of virilisation:
- Dhea (dehydroepiandosterone sulfate)
- 17 oh progesterone • Androstenedione
- Ovarian ultrasound • Adrenal imaging

Always refer patchy alopecia for a biopsy unless you are sure it is alopecia areata. If it is areata don't be shy about trying topical or intralesional steroids. 2.5 or 5% triamcinolone is best.