

Alopecia Areata - An instance of combined therapy success

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Abstract

Alopecia areata (AA) is a complex condition which is autoimmune and causes non-cicatricial hair loss. It commonly presents at any age with sharply demarcated round patches of hair loss. In this article, we are presenting a case, which was treated with basic treatment and got satisfactory results.

Keywords: satisfactory, Alopecia, necessitates

Introduction

Alopecia areata is an autoimmune, inflammatory condition that causes non-cicatricial hair loss on the scalp and/or body. Although the exact cause of alopecia areata is still unknown, the most widely recognized view is that it is a genetically predisposed person's T-cell-mediated autoimmune illness. Between 20 and 50 is when the incidence peaks. There is no racial difference noted, and both sexes are equally affected. Clinically, alopecia areata can manifest as a single, clearly defined patch of hair loss, several patches, or significant hair loss that includes complete scalp and body hair loss (alopecia universalis) or total loss of scalp hair (alopecia totalis).

Most often, the illness resolves on its own, but in a small percentage of cases, the disease progresses and necessitates active therapy in the form of oral or topically applied therapeutic choices. Severe social and emotional consequences are linked to progressive alopecia areata.

Case report

A 28-year-old female patient visited Dermatology OPD with a chief complaint of patchy loss of hair from the scalp suddenly over a period of 1 month. Initially, there were 1-2 small patches of hair loss which, with the passage of time increased in number resulting in one large patch leading to mental stress and distress. Pt. took treatment from local doctors but was not relieved. Then, she visited Dermatology OPD in our Tata Main Hospital. There was no history of hair loss from any other part of the body and no similar history in any family member was present.

On local examination, a single well-defined patchy area of non-scarring alopecia involving mid-scalp and vertex of approximate size ranging from 6x7 cm was present.

Hairs over other body sites were normal. Clinical diagnosis of alopecia areata was made by seeing the exclamation marks at the margins of patches. The results of regular testing such as the TSH, complete blood count, liver function tests, blood sugar, and kidney function tests were all normal. The patient was treated with intralesional triamcinolone 10mg/ml monthly for 5 months, Oral mini pulse, topical clobetasol lotion, tacrolimus 0.1 %, minoxidil 5% lotion, multivitamins, oral zinc for 6 months. The periodic examination was done on a monthly basis which showed gradual regrowth of hairs initially followed by complete regrowth of scalp hairs finally which restored the patient's self-confidence.

Pictures of patient

Figure 1: Before treatment, large patch of hair loss



Figure 2: Follow-up after 2 months of treatment



Figure 3: Follow-up after 5 months of treatment



Discussion

The disease alopecia areata is defined by the non-scarring hair loss on the scalp or any place that bears hair. Clinical manifestations might range from a single hair loss patch to the whole loss of hair on the scalp alopecia total is) or full body (alopecia universalis). Literature and microscopic study suggest an autoimmune origin for alopecia areata. The peribulbar inflammatory infiltrate has a predominance of T-lymphocytes, which are thought to contribute to hair loss. Alopecia areata is thought to be related to thyroiditis and vitiligo. There have been reports of autoantibodies to follicular components. For the treatment of alopecia areata, a number of medicinal agents have been created, however, none of them are curative or preventative ^{[1]. [2]}

Treatment for alopecia areata aims to slow the disease's progression. Topical and systemic therapies can be used as therapy techniques. Intralesional and topical corticosteroids, minoxidil, anthralin, and topical immunotherapy in the form of DPCP and SADBE are all included in the topical therapy. Systemic corticosteroids and photo chemotherapy are both parts of systemic therapy. Immunosuppressive medications such as cyclosporine, methotrexate, sulphasalazine, and biologics have been used with only modest success. Up to 80% of people with mild patchy hair loss that has lasted less than a year experience remission.^[3]

At the 12-week follow-up in several studies, 60-71% of patients had nearly complete hair regrowth (>75%) after receiving intralesional triamcinolone acetonide treatment. At 12 weeks, our investigation revealed that our patient's hair had grown back nearly completely (>75%).

Depending on the level of reaction, we administered 10mg/ml triamcinolone acetonide injections once every four weeks for a maximum of four months. The patient was monitored for six months.

Transient atrophy and telangiectasia are side effects of intralesional triamcinolone acetonide therapy. Transient atrophy and telangiectasia are side effects of intralesional triamcinolone acetonide therapy. Both triamcinolone acetonide itself and carboxymethylcellulose, a dispersant used in corticosteroid preparation, have been linked to anaphylactic reactions to intralesional corticosteroid injection.^[6]

To sum up, intralesional steroids continue to be the preferred method for treating localised patchy alopecia areata. In order to see a better response to therapy, a longer follow-up period is advised.

Conclusion

Intralesional steroids, oral and topical medication, and other methods of managing alopecia areata efficiently can stop the disease's natural course and restore patients' self-confidence.

Declaration of patient consent

The authors attest that they have all necessary patient permission forms on file. The patient has indicated in the form that she is okay with the photos and other clinical data being reported in the journal. She is aware that while every attempt will be made to keep her identity a secret and that her name and initials won't be published, anonymity cannot be guaranteed.

References

1. Lacarrubba F, D'Amico V, Nasca MR, Dinotta F, Micali G. Use of dermoscopy and video dermoscopy in therapeutic follow-up: A review. *Int J Dermatol* 2010; 49:866-73.
2. AL khalifah A, AL Santali A, Wang E, McElwee KJ, Shapiro J. Alopecia areata update: Part II. treatment. *J Am Acad Dermatol* 2010; 62:191-202.
3. Ikeda T. A new classification of alopecia areata. *Dermatologica* 1965; 131:421-45.
4. Abell E, Munro DD. Intralesional treatment of alopecia areata with triamcinolone acetonide by jet injector. *Br J Dermatol* 1973; 88:55-9.
5. Kuldeep C, Singhal H, Khare AK, Mittal A, Gupta LK, Garg A. Randomized comparison of topical betamethasone valerate foam, intralesional triamcinolone acetonide and tacrolimus ointment in the management of localized alopecia areata. *Int J Trichology* 2011; 3:20-
6. De Souza BA, Ban tick G. Anaphylactic reaction to intralesional steroid injection. *Plast Reconstr Surg* 2006; 117:336.