



Alopecia Areata is a common dermatosis associated with **non-scarring** hair loss.

Higher rates reported among children from Asian, Black, and Hispanic backgrounds.

Reported **lifetime risk** of 1-2%.



Patchy hair loss

INVESTIGATIONS

- Commonly diagnosed **clinically**.
- Supported with **trichoscopic examination** and **skin biopsy**.
- Consider other investigations (blood tests) if risk factors or clinical indications present for associated autoimmune conditions

DIFFERENTIAL DIAGNOSIS

- Tinea capitis**: fungal infection causing hair loss that is scaling and pruritic
- Trichotillomania**: irregular patches of incomplete hair loss often in frontoparietal regions.
- Telogen effluvium**: diffuse hair shedding leading to hair thinning occurring typically 3 months after a physiologic or emotional stressor

PATHOPHYSIOLOGY

- Familial**: genetic predisposition and polygenic.
- Autoimmune response**: linked with comorbidities (atopic dermatitis, autoimmune thyroiditis, IBD, SLE, vitiligo).
- Triggers**: emotion/physical stress, infections or medications.

PRESENTATION

- Multiple clinical subtypes**
- “Patchy”** is most common. The patches either show total hair loss, or fine vellus hair growth.
- Can progress to all scalp hairs: **“alopecia totalis”** or all scalp and body hair: **“alopecia universalis”**
- Well-defined round or oval shape on any hair-bearing body site, including eyebrows and eyelashes.
- Affected areas have normal smooth skin appearance without scaling or inflammation.
- Nail changes such as pitting, brittleness and striations

MANAGEMENT

- Initial **“wait and see”** approach: possible spontaneous recovery within a year.
- Dermatology** referral for extensive hair loss or refractory cases.
- First/second line therapy may vary based on severity of hair loss and age
 - **First-line therapy**: Medium to high potency topical steroids, intralesional steroids, topical minoxidil
 - **Second-line therapy**: Topical immunotherapy, systemic steroids, Janus kinase inhibitors