Traumatic alopecia

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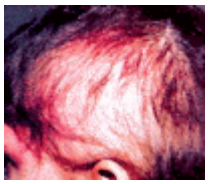
Introduction

The term traumatic alopecia is applied to alopecia induced by physical trauma. These cases fall into three main categories:

1. Alopecia resulting from the deliberate, though at times unconscious, efforts of the patient, who is under tension or is psychologically disturbed - **trichotillomania**.
2. Alopecia resulting from cosmetic procedures applied incorrectly or with misguided and excessive vigour or frequency - **cosmetic alopecia**.
3. Alopecia resulting from accidental trauma - **accidental alopecia**.

Trichotillomania

Introduction: Hallopeau suggested the term trichotillomania in 1889 for the compulsive habit, which induces an individual to pluck his or her own hair repeatedly. There are obvious objections to this overdramatic term for what is often a trivial problem.



Pathology: (See Fig) The histological changes vary according to the severity and duration of the hair plucking. Numerous empty canals are the most consistent feature. Some follicles are severely damaged; there are clefts in the hair matrix, the follicular epithelium is separated from the connective tissue sheath, and there are intra-epithelial and perifollicular haemorrhages and intrafollicular pigment casts. Injured follicles may forxn only soft, twisted hairs - a process which has been described as a separate entity under the name of trichomalacia. Many follicles are in catagen, with very few or no follicles in telogen. Some dilated follicular infundibula contain horny plugs.

Etiology and psychopathology: Trichotillomania occurs more than twice as frequently in females as in males but below the age of 6 years boys outnumber girls by 3:2 and the peak incidence in boys is in the 2-6 age group. It is seven times more frequent in children than adults. The child develops the habit of twisting hair round its fingers and pulling it. The act is only partially conscious and may replace the habit of thumb sucking. Various psychiatric studies are not in complete agreement, but emotional deprivation in the maternal relationship is considered important in initiating the habit.

The rarer and more severe form occurs predominantly in females of any age from early adolescence onwards, and most are aged 11-40 years; the peak incidence in females is between 11 and 17 years. The hair pulling begins in a provocative social situation in a subject who is often greatly disturbed psychologically. Exceptionally severe forms may be seen in young patients and the minor forms in older patients.

Clinical features: In the younger patients the hair-pulling tic develops gradually and unconsciously but is not usually denied by the patient. Hair is plucked most frequently from one frontoparietal region. There results an ill-defined patch on which the hairs are twisted and broken at various distances from the clinically normal scalp. The texture and color of the broken hairs are of course unaffected.

In the more severe form the patient usually consistently denies that she is touching her hair. The patient presents with an extensive area of scalp on which the hair has been reduced to a coarse stubble uniformly 2.5-3 mm long. Most characteristically, the plucked area covers the entire scalp apart from the margin (See Fig), hence the validity of the term 'tonsure alopecia'. The hair plucking may be continued for years and the disfiguring baldness is held by the patient to be responsible for her psychological problems. A mother and daughter have been affected at the same time.

Much more unusual is the habit of plucking the eyelashes, eyebrows and beard. Very exceptionally the patient may pluck hair also, or only, from other regions of the body, such as the mons pubis and perianal region.

The child may also suck and even eat the hair (trichophagy). In such cases, examination of the mouth may reveal hairs and enquiry should be made for systemic symptoms related to the presence of a hairball, e.g. dysphagia, vomiting, anaemia, abdominal pain or constipation. This symptom was present in 10% of children with trichotillomania.

Differential Diagnosis: The minor form in young children is often confused with ringworm or with alopecia areata. In ringworm the texture of the infected hairs is abnormal and the scalp surface may be scaly. It is wise to examine all cases under Wood's light and also to examine broken hairs under the microscope. Alopecia areata may be difficult to exclude with certainty at the first examination, but the course of the condition soon establishes the correct diagnosis; histology may be very useful in early lesions. We have known the hair-pulling tic to develop in a child recovering from typical alopecia areata.

Treatment and prognosis: The habit tic in young children is usually eradicated, except in the mentally retarded. The child's problem should be discussed with them and their parents. The parents who have not observed the child pulling the hair and find it unacceptable to believe that the problem is self-inflicted often reject the diagnosis. Behavior therapy is also suggested to be helpful.

Homoeopathic Treatment: Remedies like Belladonna, Cuprum Met, Ignatia, Rhux Tox, Selenium, Sulphur and Nat Mur are useful in this condition.

Cosmetic traumatic alopecia

The dictates of religion, of custom and of fashion have imposed an immense variety of physical stresses on human hair. The nomenclature of the resulting patterns of baldness inevitably lacks any consistency. It is possible only to list the clinical syndromes most widely reported; any new hairdressing technique may give rise to new patterns.

Pathology: Two processes are responsible for most of the pathological changes observed. Hair, sometimes already weakened by chemical applications, may be broken by friction or by tension. Prolonged tension may induce follicular inflammatory changes, which may eventually lead to scarring. Traction alopecia is induced particularly readily in subjects with incipient common baldness, for the telogen hairs, which make up a higher proportion of the total, are more readily extracted than anagen hairs.

Traumatic and marginal alopecia: The essential changes in the many variants of this syndrome are the presence of short broken hairs, folliculitis and some scarring in circumscribed patches at the scalp margins.

In one form, which is caused by the tension imposed by procedures intended to straighten kinky hair, alopecia commonly begins in triangular areas in front of and above the ears, but may involve other parts of the scalp margin, or even linear areas in other parts of the scalp. Itching and crusting may be pronounced. The so-called 'pony-tail' hairstyle may cause similar changes in the frontal hair margin. Keratin cylinders - 'hair casts' - may surround many hairs just above the scalp surface.

Frontal and parietal traction alopecia may occur in young Sikh boys as a result of twisting their uncut hair tightly on top of the head, and tight braiding and wooden combs produce traction alopecia in the Sudan; frontal loss is reported in Libyan women as a result of traction from a tight scarf.

Afro-Caribbean hairstyles with tight braiding of the hair into rows known Variously as corn, cain or cane rows or braids may cause marginal alopecia and central alopecia with widening of the partings.

Brush roller alopecia: Brush rollers, if applied frequently and with too much vigour, may cause irregular patches of more or less complete alopecia, surrounded by a zone of erythema with broken hairs.

Hot-comb alopecia: Negro women who use hot combs to straighten the hair may develop a progressive cicatricial alopecia, slowly extending centrifugally from the Vertex. This procedure is now rarely carried out.

Massage alopecia: The over-enthusiastic application of medication to the scalp, with firm massage, may cause baldness and excessive 'weathering' (trichorrhexis nodosa).

Brush alopecia: Vigorous brushing may cause significant damage to hair that is already fragile as the result of a developmental defect. The bristles with square or otherwise angular tips, present in some brushes made of synthetic fibres, may prove particularly traumatic.

Alopecia secondary to hair weaving: Patchy traction alopecia has been reported to result from the cosmetic procedure of weaving additional hair into persistent terminal hair in order to camouflage common baldness.

Deliberate alopecia: We have seen a family from Pakistan in which three sisters during childhood were subjected to tight plaiting and traction of the central V of the frontal hair. The resulting V alopecia was considered desirable.

Diagnosis: The traumatic cosmetic alopecias do not present any diagnostic difficulties, provided the possibility is considered. Their cause is rarely recognized by the patient and is often accepted with suspicion.

Homoeopathic Treatment: Remedies like Borax, Thuja, Acid Flour, Mezerium, Sulphur can be used to treat above hair disorders. However other remedies may be included as per individual symptoms.

Accidental traumatic alopecia

Alopecia secondary to accidental mechanical trauma to the scalp is usually no diagnostic problem but in some circumstances the trauma may be unperceived and the cause of the hair loss undetected.

Women who had undergone prolonged pelvic operations in the Trendelenburg position developed, 12-26 days later, a vertical patch of alopecia which was preceded by oedema, exudation and crusting. Pressure ischaemia during the operation was considered to be the cause of the alopecia. In one large clinic, over a period of 3 years 60 cases of occipital pressure alopecia were observed after open-heart surgery. In 29 of these cases, the hair loss was permanent. Temporary alopecia followed prolonged pressure on the scalp by a foam rubber ring used to prevent such an occurrence.

Homoeopathic Treatment: Most common indicated remedies are Hypericum, Arnica Mont, Ruta G & Cantharis.

Warning: Please do not take medicines given in this article on your own. They are provided for information purpose only! It is advisable to seek professional Homoeopathic consultation.