

# Guidelines for the Management of Alopecia Areata

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## Background

Alopecia areata is a chronic inflammatory disease affecting the hair follicle and sometimes the nails. The predisposition to alopecia areata is polygenic; diverse environmental factors have been implicated in triggering the disease.

## Prognosis

Spontaneous recovery occurs within 6-12 months in most patients (~80%) with limited patchy hair loss. The prognosis is less favourable in patients referred to secondary care (35-50% recovery within one year). Poor prognostic indicators include ophiasis, extensive disease and onset in childhood. Recovery is unusual in alopecia universalis (<10%).

## Management

There are very few controlled trials and no evidence that treatment alters natural history.

*Counselling* should include discussion of the nature of alopecia areata, its prognosis, the treatment options and sources of further information and support.

'No treatment' is a legitimate option in view of high spontaneous remission in mild forms of alopecia areata and limited efficacy of treatments in severe disease.

*Intralesional steroid* An effective treatment in patchy alopecia areata of limited extent. Hydrocortisone acetate 25mg ml<sup>-1</sup> or triamcinolone acetonide 5-10mg ml<sup>-1</sup> (Adcortyl) may be used. Not suitable for extensive alopecia. Can be helpful for eyebrows (*Strength of Recommendation B; Quality of Evidence III*).

*Topical steroids* Limited evidence of efficacy for potent topical steroids used under occlusion in AT/AU (17.8% longterm response) (*Strength of Recommendation B; Quality of Evidence II-i*).

*Contact immunotherapy* Reasonable evidence of efficacy in extensive alopecia areata though wide variation in published response rates (9-87%) and AT/AU less likely to respond. Most clinicians use diphenylcyclopropenone (DPCP) once weekly. Main side effect is severe dermatitis – this can be minimised by careful titration of DPCP concentration. Not widely available (*Strength of Recommendation B; Quality of Evidence II-ii*).

*Topical minoxidil* Good safety profile but poor evidence of efficacy. Ineffective in AT/AU (*Strength of Recommendation C; Quality of Evidence IV*).

*Dithranol* Good safety profile but poor evidence of efficacy. Ineffective in AT/AU (*Strength of Recommendation C; Quality of Evidence IV*).

*Photochemotherapy* Limited evidence of efficacy. Relapse rates high and risks of continued treatment outweigh benefits (*Strength of Recommendation C; Quality of Evidence III*).

*Systemic steroids* Uncontrolled studies using pulsed high-dose regimens suggest benefit in patchy AA but long-term outcomes unknown. One placebo-controlled study reported 25% response at 3 months in extensive alopecia areata. The use of systemic steroids in alopecia areata is controversial in view of the risks and uncertain long-term efficacy (*Strength of Recommendation C; Quality of Evidence III*).

*Wigs* A wig or hair piece can be very helpful in women with extensive alopecia areata. Wigs are less successful in men.

*Children* Aggressive treatments, such as contact immunotherapy and intralesional steroids are less appropriate for children. Parents and patients may require considerable support.

**Reference:**

Br J Dermatol 2003; 149: 692

**Production of this guideline summary was kindly sponsored by the British National Formulary**