Living with Alopecia

Real live Cases from Daily Practice

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- **No conflict of interest**

When is Systemic Treatment Needed?

Intralesional Triamcinolone is the mainstay of therapy for ***limited*** scalp hair loss

Intralesional triamcinolone administration: ~0.1 mL every 1-2 cm^2

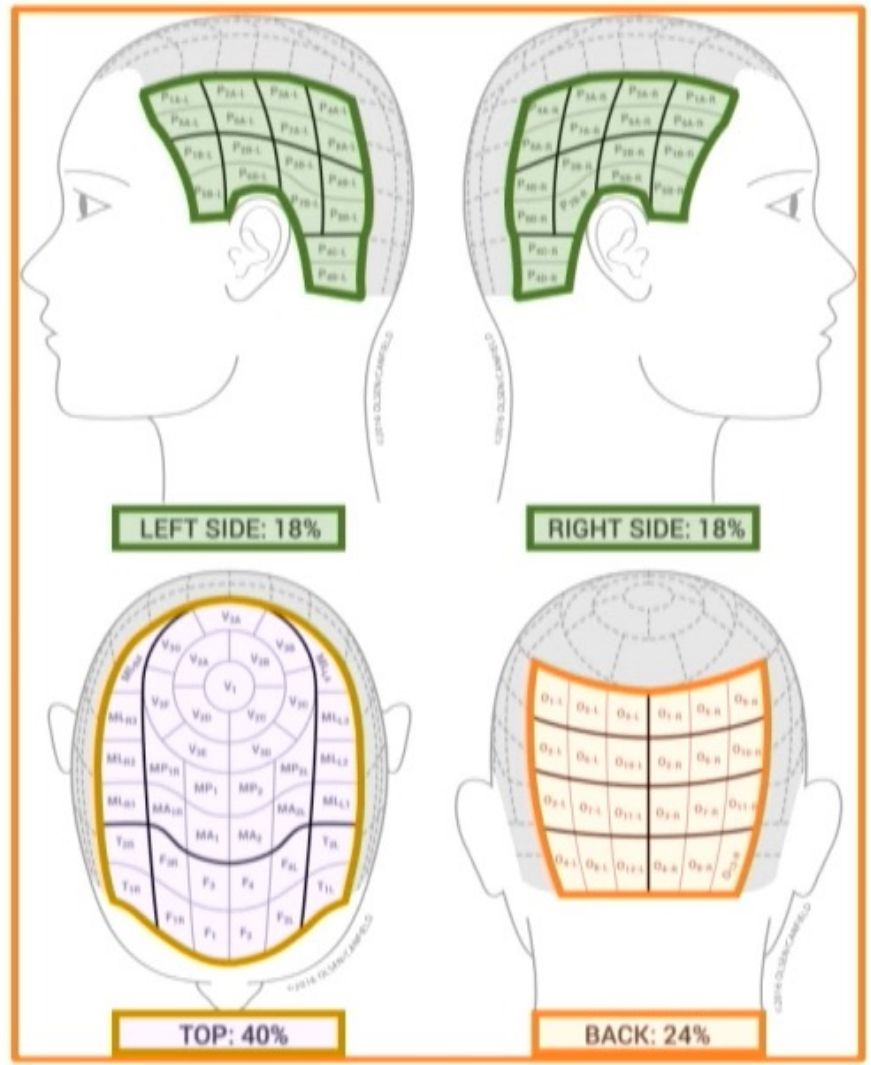
1% of the SSA is ~7 cm^2

10% loss = ~70 cm^2 = ≥35 injections

20% loss = ~140 cm^2 = ≥70 injections

AA involving >20% of the SSA merits systemic therapy

The average hair-bearing surface area of the scalp is 705 cm^2



ILK = intralesional Kenalog

SSA = scalp surface area

Chu TW, et al. *J Am Acad Dermatol.* 2015;73:338-340. Olsen EA, Canfield D. *J Am Acad Dermatol.* 2016;75:1268-1270.

Alopecia areata scale (AASc)

AA Severity	% Scalp hair loss
Mild	≤20
Moderate	21-49
Severe	50-100

If mild or moderate, increase AA severity rating by one level if one or more of the following is present:

- *Noticeable involvement of eyebrows or eyelashes*
- *Inadequate response after at least 6 months of treatment*
- *Diffuse (multifocal) positive hair pull test consistent with rapidly progressive AA*
- *Negative impact on psychosocial functioning resulting from AA*

King BA et al. *J Am Acad Dermatol*. 2021;S0190-9622(21)02387-2.

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REVIEW ARTICLE

JEADV JOURNAL OF THE EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

European expert consensus statement on the systemic treatment of alopecia areata

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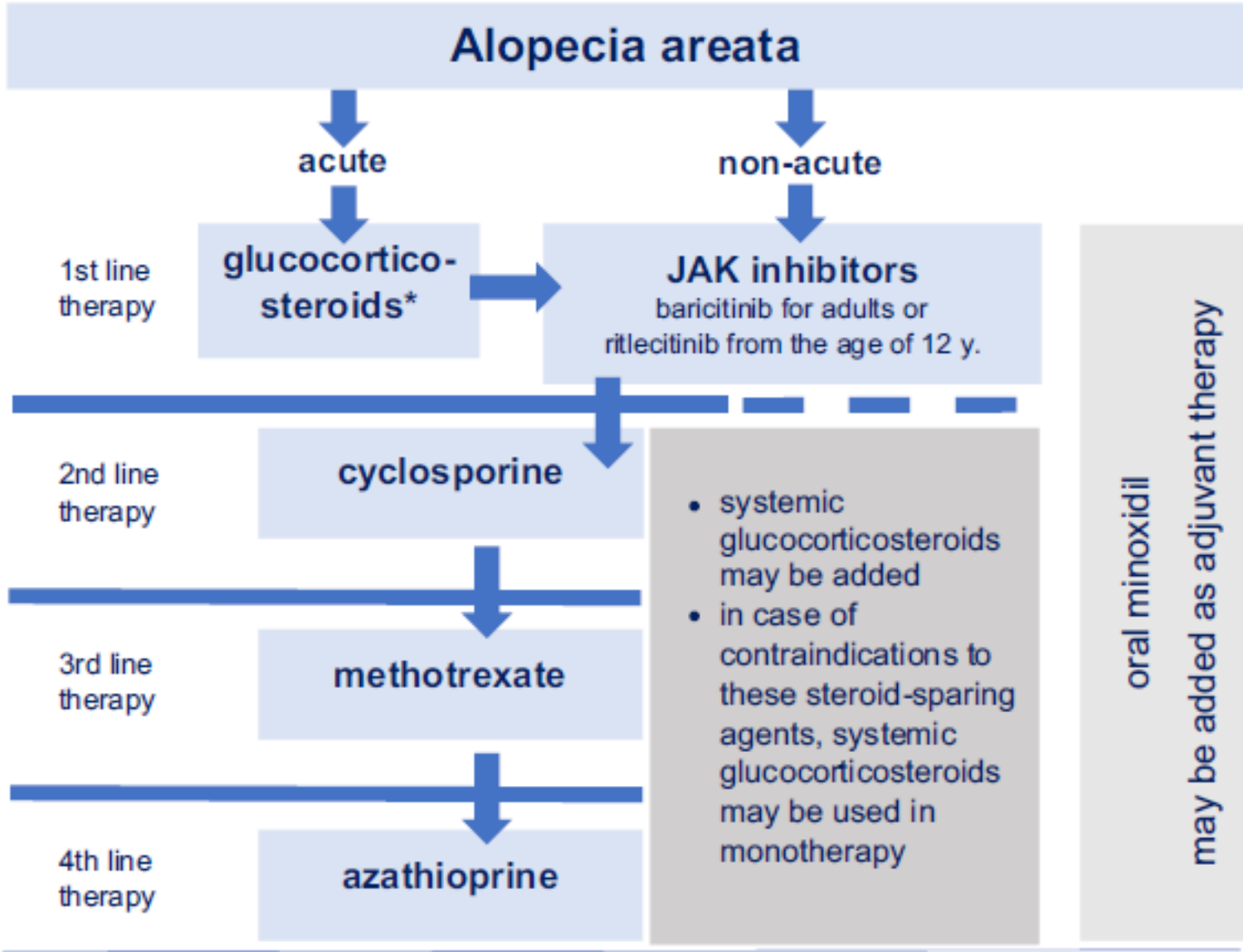
J Eur Acad Dermatol Venereol. 2024;38:687–694.



A suggested therapeutic algorithm for the systemic treatment of alopecia areata.

Killing Two Birds with One Stone: Oral Tofacitinib Reverses Alopecia Universalis in a Patient with Plaque Psoriasis

Journal of Investigative Dermatology (2014) **134**, 2988–2990; doi:10.1038/jid.2014.260; published online 17 July 2014

TO THE EDITOR

The patient is a 25-year-old male who presented for evaluation and management of plaque psoriasis, which had begun 5 years earlier. Treatment with topical corticosteroids had not been particularly helpful, and, because of the involvement of psoriasis over an increasing body surface area, systemic therapy with adalimumab had been initiated 1 year before. Although clearing of psoriasis was experienced early in the course of adalimumab, the improvement faded. In addition to psoriasis, the patient reported a history of alopecia areata (AA) beginning at around age 2 years, which progressed to alopecia universalis (AU) by age 18 years. Treatment of the alopecia with topical corticosteroids had not been effective, and he had received no other therapy for it. He had no family history of either psoriasis or AA, and his past medical history was otherwise unremarkable.

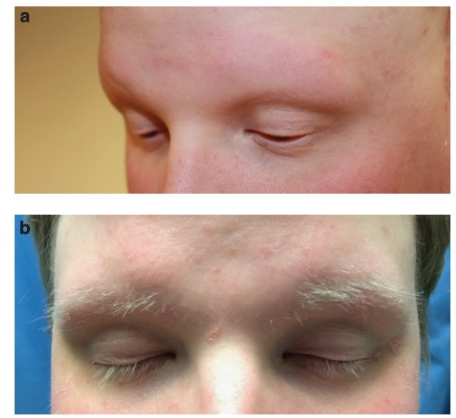


Figure 1. Representative photographs of patients eyebrows and eyelashes before treatment and after 8 months. Eyebrows and eyelashes at baseline (**a**) and after 8 months of therapy (**b**).

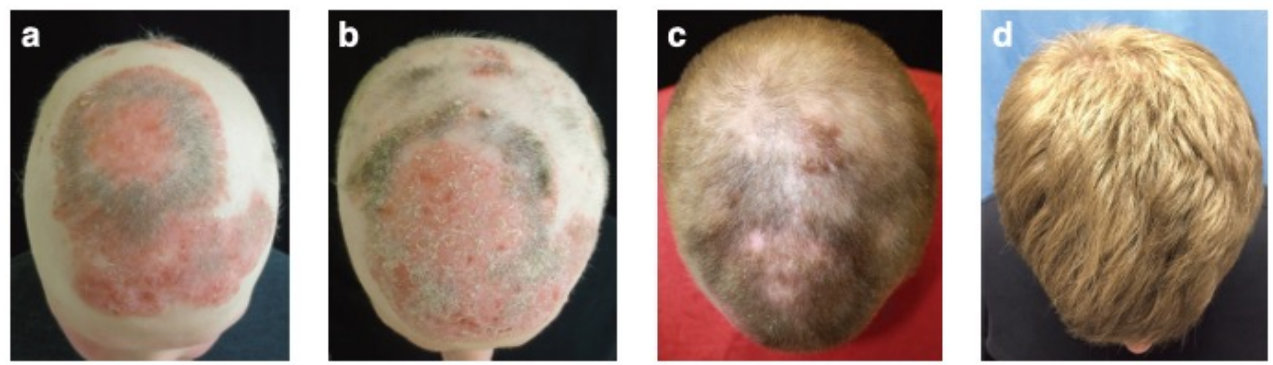


Figure 2. Representative photographs of the patient's scalp at intervals of therapy. (**a**) Scalp of the patient at baseline. The only prominent hair growth is seen within psoriatic plaques. (**b**) Scalp after 2 months of therapy. Prominent hair growth is now visible outside of areas affected by psoriasis. Psoriasis is beginning to recede in areas. (**c**) Scalp after 5 months of therapy. There is near-complete regrowth of scalp hair. Psoriasis continues to be present but is significantly improved compared with baseline. (**d**) Scalp after 8 months of therapy. There is complete regrowth of scalp hair.

Disease Modification in AA

Are we moving towards a cure?

Or at least, modify the disease course?

Disease Modification: Sustained Clinical Benefit

Modifying pathophysiology to give sustained clinical benefit:

1. Delay or slowing of disease progression.
2. Prevention of associated disease or co-morbid conditions
3. Delay of disability
4. Alteration other areas of disease course.

- Need to alter underlying pathophysiology of disease, not symptomatic relief.

Morant, AV. Policy and Practice Reviews. 2019

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