STANDARD TREATMENT WORKFLOW (STW)

ALOPECIA / HAIR LOSS

Binod K Khaitan, Deepika Pandhi, Ananta Khurana, Dipankar De, Rahul Mahajan, Renu George, Vishal Gupta

1All India Institute of Medical Sciences, New Delhi; 2University College of Medical Sciences, New Delhi; 3Dr. Ram Manohar Lohia Hospital, New Delhi; 4Postgraduate Institute of Medical Education and Research, Chandigarh; 5Postgraduate Institute of Medical Education and Research, Chandigarh; 6Christian Medical College, Vellore; 7All India Institute of Medical Sciences, New Delhi

CORRESPONDING AUTHOR
Dr Binod K Khaitan, Department of Dermatology, All India Institute of Medical Sciences, New Delhi
Email: binodkhaitan@hotmail.com

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Khaitan BK, et al.: ALOPECIA / HAIR LOSS

**CONGENITAL**
- Alopea due to inherited/congenital disorders with or without easy hair breakage
- Congenital hypotrichosis
  - Monilialex
  - Trichorrhexis nodosa
  - Loose anagen hair syndrome
  - Woolly hair syndrome
- Refer to tertiary centre for further evaluation

**ACQUIRED**
- Telogen effluvium
- Hair thinning with widening of portion usually in postmenopausal women
  - Topical minoxidil solution 5% for local application
  - Treatment of underlying condition
  - Severe non-responsive: refer to tertiary care
  - Oral anti-androgens (Finasteride, Spironolactone, cyproterone acetate with oral contraceptives may be added)
- Female pattern hair loss
- Pattern hair loss
- Male pattern alopecia
- Anagen effluvium
- Linear shedding
- Telogen effluvium
- With fall of up to 100 per day may be normal and need not cause alarm
- Regular cleaning of scalp and hair with plain shampoo
- Avoid hair oil application and damaging mechanical/chemical hair care procedures

**NON SCARRING ALOPECIA (SMOOTH BALD AREAS WITH SMALL BLACK INTACT HAIR POLICLES)**
- Patchy
- Diffuse
- Alopecia areata
  - Asymptomatic, single/multiple smooth bald patches, can progress to involve whole scalp (alopecia totalis) or all body hairs (alopecia universalis)
  - Hob nailing, exam for nail pitting
  - 60% of scalp: Topical 0.05% betamethasone lote OD, intralesional Triamcinolone once in 2-4 weeks 5 mg/ml for scalp and 25 mg/ml for beard or eyebrows, only for limited involvement, topical minoxidil 5% OD
  - 40% scalp or involvement of face and body hairs or margin of occipital area: refer to tertiary centre to be worked up for immune suppressants such as oral steroids mini pulse, Methotrexate or Cyclosporine
- Tinea capitis
  - Children with patches of hair loss with scaling and/or signs of inflammation (erythema, pruritus, boggy swelling). Easy pluckability of hair within the patch
  - KOH mount for confirmation, if available
  - Oral antifungals: Griseofulvin 10-20 mg/kg, Terbinafine 5 mg/kg for 4-6 weeks
  - Topical antifungal shampoos
  - Avoid comb sharing
- Trichotillomania
  - Children and young adults with bizarre shaped bald patches with broken hair of different length and focal scalp hemorrhages
  - Look for other signs of impulsive behaviour
  - Counselling and referral to psychiatrist if needed

**SCARING ALOPECIA (AREAS WITH FIBROSIS AND DAMAGE TO HAIR FOLLICLES)**
- All cases of scarring alopecia must be referred to a dermatologist for histological confirmation & further management
- Pigmentary changes
  - Due to trauma/ burns/ dermatoses like morphea, pemphigus, neoplasms affecting the scalp
- Discoid lupus erythematosus
  - Erythematous plaques with atrophy, scaling and follicular plugging
  - Skin biopsy
  - Investigation and treatment of underlying disorder

**HIGH REGROWTH POTENTIAL WITH NON-SCARING ALOPECIA, GUARDED REGROWTH POTENTIAL WITH SCARING ALOPECIA**
- Trichoscopy, scalp biopsy for histopathology
- Treatment: Oral steroid mini pulse +/- Methotrexate/ Azathioprine/ Cyclosporine for halting active progression
- Strict laboratory monitoring for any adverse drug events
- For burnt out disease: wigs and camouflage

**STANDARD TREATMENT WORKFLOW (STW)**
**ALOPECIA / HAIR LOSS**
**ICD-10: LS5.9**

**DEFINITION**
- Excessive hair shedding and/or spanning leading to visible scalp that may be either patches or diffuse

**HISTORY & EXAMINATION**
- Elicit history pertaining to:
  - Duration and age of onset of hair loss
  - Whether patchy or diffuse scalp involvement, and if other hair bearing areas are affected
  - Relevant medical history pertaining to specific entities mentioned below
  - Specific features including cosmetic hair procedures

**GENERAL HAIR CARE PRINCIPLES**
- Hair fall of up to 100 per day may be normal and need not cause alarm
- Regular cleaning of scalp and hair with plain shampoo
- Avoid hair oil application and damaging mechanical/chemical hair care procedures

**Investigations: Trichoscopy, scalp biopsy for histopathology**
- Treatment:
  - Oral steroid mini pulse +/- Methotrexate/ Azathioprine/ Cyclosporine for halting active progression
  - Strict laboratory monitoring for any adverse drug events
  - For burnt out disease: wigs and camouflage

**Investigations: Trichoscopy, scalp biopsy for histopathology**
- Treatment:
  - Photoprotection
  - Topical steroids
  - Hydroxychloroquine 5mg/kg/day after baseline ocular examination, usually required for 6-12 months

This guideline has been prepared by national experts of India with feasibility considerations for various levels of healthcare system in the country. These broad guidelines are advisory, and are based on expert opinions and available scientific evidence. There may be variations in the management of an individual patient based on his/her specific condition, as advised by the treating physician. There will be no indemnity for direct or indirect consequences. Kindly visit the website of DHR for more information: stw.imc.org.in for more information.

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