Traction Alopecia in a Young Girl

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Acute Dx: What Cause of Sudden Illness?

THE CASE:
The parents of a 4-year-old girl are concerned because she has experienced hair loss for several weeks. The child is otherwise healthy and active, has no known disorders, and takes no medications. What do you suspect?

- Tinea capitis
- Trichotillomania
- Traction alopecia
- Discoid lupus erythematosus

(Answer and discussion on next page.)

DISCUSSION: This child has traction alopecia an entity first described in 1907 in girls and women in Greenland who styled their hair in a ponytail. It is found primarily in African American women and girls and is also seen in Japan. In India, the condition is observed in Sikh men who pull their scalp hair into a bun and tightly roll their beard hair.

Hairstyling practices such as braiding, cornrows, and the use of weaves and rollers may also cause traction alopecia. Sustained tension on the scalp results in breakage of the outermost hairs. Hair loss is often symmetric; it frequently occurs along the frontotemporal hairline. The initial loss is reversible; however, prolonged traction may result in permanent hair loss.

In the first stages of traction alopecia, pruritus and perifollicular erythema are often present. They may be accompanied by secondary hyperkeratosis that resembles seborrheic dermatitis. Over time, scales and pustules may develop. Eventually, follicular atrophy results in the replacement of normal long, coarse hair by thinner, finer short hair.

Traction alopecia may be marginal or nonmarginal. Marginal alopecia (alopecia linearis frontalis) is a pattern of hair loss associated with the use of rollers, tight curlers, or straighteners in childhood. It occurs in the temporal region of the scalp and extends in a triangle from the preauricular area. Chignon alopecia is a form of nonmarginal alopecia that is characterized by hair loss in the occipital region where a bun is located. This condition is typically seen in middle-aged women who have pulled their hair into a bun for many years.

Early diagnosis is important to help prevent irreversible hair loss. Once the offending practices have been discontinued, it may take several months before regrowth occurs. Antibiotics may be required for secondary inflammation and infection. No medical treatment is available once hair loss has become irreversible; hair transplantation procedures may be considered.

Trichotillomania, a traumatic alopecia, is a psychiatric disorder characterized by compulsive hair pulling that results in patchy hair loss. Hair loss may cover from several centimeters to large portions of the scalp. In addition to the scalp, the eyebrows, eyelashes, and pubic area may be affected.
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Treatment is directed toward the underlying disorder. Most adult and teenage patients are women; in younger patients, boys are affected slightly more often than girls. In children, nail biting may be seen concurrently with trichotillomania. 

*Tinea capitis* is the most common dermatophytosis of childhood (it accounts for up to 90% of dermatophytoses in children younger than 10 years) and is characterized by partial alopecia and scaly patches. This superficial fungal infection affects the skin of the scalp, eyelashes, and eyebrows. The affected areas have hairs broken 1 to 3 mm above the skin. Patches of hair loss occur singly or in groups and are usually round or oval. *Microsporum* and *Trichophyton* are the usual culprits. The diagnosis is confirmed by Wood lamp examination, potassium hydroxide wet-mount preparations, or fungal cultures.

*Discoid lupus erythematosus* is a chronic dermatosis that primarily affects women aged 40 to 60 years. The lesions consist of erythematous papules or plaques with slight to moderate scaling and are characterized by central hypopigmentation with peripheral areas of hyperpigmentation. The lesions are most commonly seen on the head and neck but may extend to the oral cavity, arms, palms, and soles. Atrophy and scarring alopecia of the scalp are typical findings.

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