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Department of Health Research
Ministry of Health and Family Welfare, Government of India

INDIAN COUNCIL OF MEDICAL RESEARCH
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Standard Treatment Workflow (STW)

ALOPECIA / HAIR LOSS

ICD-10-L63.9

DEFINITION
Excessive hair shedding and/ or sparsening leading to visible scalp that may be either patchy or diffuse

HISTORY AND 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
- Hair care practices including cosmetic hair procedures

Examine scalp for scarring vs non-scarring by looking for
- Loss of skin markings
- Loss of hair follicle ostia
- Pigmentary changes

GENERAL HAIR CARE PRINCIPLES
- Hair fall of upto 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 FOLLICLES)

CONGENITAL

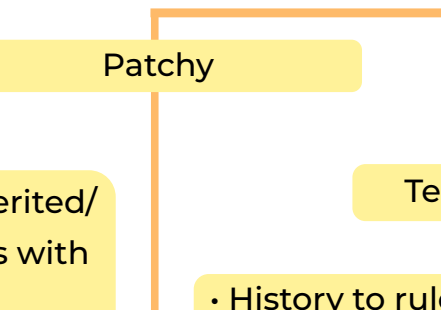
Alopecia due to inherited/ congenital disorders with or without easy hair breakage
- Congenital hypotrichosis
- Monilethrix
- Trichorrhexis nodosa
- Loose anagen hair syndrome
- Woolly hair syndrome

Refer to tertiary centre for further evaluation

ACQUIRED

Patchy

Alopecia areata

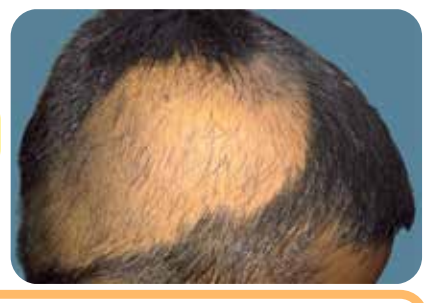


- Asymptomatic, single/ multiple smooth bald patches; can progress to involve whole scalp (alopecia totalis) or all body hairs (alopecia universalis)
- H/o atopy, examine for nail pitting
- <50% of scalp: Topical 0.05% Betamethasone lotion OD, intralesional Triamcinolone once in 2-4 weeks (5 mg/ml for scalp and 2.5 mg/ml for beard or eyebrows) only for limited involvement, topical Minoxidil 5% OD
- >50% of scalp or involvement of facial and body hairs or margin of occipital area: refer to tertiary centre to be worked up for immunosuppressants 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, pustulation, 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 6-8 weeks
- Topical antifungal shampoos
- Avoid comb sharing

Trichotillomania



- Children or young adults with bizzare 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

Diffuse

Telogen effluvium
- History to rule out underlying medical illness, drug intake, menstrual irregularities, hypo/ hyperthyroidism, anemia, physical/ mental stress
- Labs- Hemogram, and if indicated serum ferritin, TSH
- Reassurance and treatment of underlying disorder. If persistent, consider 1 ml of 5% topical Minoxidil once a day

Pattern hair loss

Androgenetic alopecia: males
- Adult males with fronto-temporal hairline thinning or recession, it may progressively involve vertex & parietal areas with usual sparing of occipital area
- Treat with 1mL of topical 5% Minoxidil solution BD
- If effective continue this treatment to maintain hair growth
- Addition of oral Finasteride 1 mg/day may be considered
- Can be referred to trained specialist for hair transplant, if required

Female pattern hair loss
- Hair thinning with widening of partition usually in postmenopausal women
- In premenopausal, look for signs of hyperandrogenism. If present, hormonal workup to rule out PCOS or virilising tumors of ovary/ adrenal glands
- 1 ml of 5% Minoxidil solution OD 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)

SCARRING 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

Primary

Pustules or boggy lesions

Folliculitis decalvans
Dissecting cellulitis of scalp

Investigations:
- Trichoscopy, scalp biopsy for histopathology

Treatment:
- Long term oral antibiotics: Doxycycline/ Clindamycin for 10-12 weeks
- Consider low dose oral steroids
- Isotretinoin

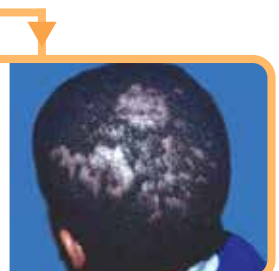
Pigmentary changes

Lichen plano pilaris
Violaceous plaques and follicular plugs. Examine for lichen planus of other sites

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

Discoid lupus erythematosus
Erythematous to depigmented plaques with atrophy, scaling and follicular plugs



Investigations:
- Trichoscopy, scalp biopsy for histopathology, direct immunofluorescence, workup to rule out SLE

Treatment:
- Photoprotection
- Topical steroids
- Hydroxychloroquine 5mg/kg/day after baseline ocular examination; usually required for 6-12 months

Secondary

Due to trauma/ burns/ dermatoses like morphea, pemphigus, neoplasms affecting the scalp

Investigation and treatment of underlying disorder

☛ HIGH REGROWTH POTENTIAL WITH NON-SCARRING ALOPECIA, GUARDED REGROWTH POTENTIAL WITH SCARRING ALOPECIA