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Considering Hair Loss Disorders in Patients with Skin of Color

Announcer:
Welcome to ReachMD.

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Pfizer does not have an FDA approved treatment for Alopecia Areata.

Drs. King and McMichael are consultants for Pfizer.

Dr. Brett King:
Hello, everybody. I'm Dr. Brett King, Associate Professor of Dermatology at the Yale School of Medicine. In previous episodes of this series, we have reviewed the presentation and diagnosis of pediatric and adult alopecia areata. In this episode, I am super excited to have Dr. Amy McMichael with us to discuss AA in patients with skin of color.

We have recently been made aware that our medical education has been deficient in teaching around diagnosis and management of dermatologic disease in patients with skin of color. And so this is a special opportunity to not only talk about alopecia areata, but to go beyond alopecia areata and to discuss hair disorders, hair loss disorders in patients with skin of color, and cultural considerations therein.

Dr. McMichael, welcome. And please tell us about yourself and your clinical practice.

Dr. Amy McMichael:
Dr. King, thank you so much for the invitation to participate today. This is really an exciting topic and I'm just really glad to be here. I am a Professor of Dermatology at Wake Forest University School of Medicine in Winston-Salem, North Carolina. I've been here for about 28 years, and for that same amount of time, I've done a hair clinic every week.

I love seeing my hair patients, but I am a general dermatologist who even does just a little bit of cosmetics. So I try to keep all of my skills really at the ready. But really, truly, my passion has been clinical and research evaluation of patients with hair loss. I have studied pretty much every form of hair loss that there is.

Dr. Brett King:
Wow. It's so amazing to have an expert like yourself with us. And so it's going to be really exciting to have this discussion and for everybody to have the opportunity to learn from you.

Having you here with us, we would like to discuss alopecia areata and hair loss disorders in Black people. I'd like to start with the basics and have you tell us what we need to know as clinicians about differences in hair among people of color.

Dr. Amy McMichael:
Well, that's a good place to start. You know, we know that the hair follicle and the hair shaft are quite different across races. But really, you know, this idea that people of African descent have a little bit more to talk about, I think is true. So, you know, first we can look at the hair shaft.

The hair shafts tend to be a little bit more ovoid, flattened, kind of. And so, that, added to the fact that the hair follicle itself is coiled and the hair comes out in a curlier coil fashion, makes it already an interesting difference, you know, as compared to, say, for instance, Caucasian or Asian hair. We also know, and we don't quite understand why, we also know that the hair shaft itself is actually quite fragile.

So there's a significant amount of hair fragility and we think that there's probably some, as yet unmeasured, difference in the hair shaft that makes this happen. But, as a result, when any kind of stress, you know, whether it's heat or chemical, is applied to that, you know, sort of fragile hair with the coiled shape, it becomes easily breakable, so that's a real big concern. And we know, also, that people of African descent have fewer hair follicles on their head, period, as compared to Caucasian and Asian patients. And we also know that the hair grows slower. So we've, you know, got this, you know, sort of tripartite issue of increased fragility, slow growing hair, and fewer follicles to deal with no matter what the form of alopecia is that we're talking about.

Dr. Brett King:
So with these considerations about these differences, which are really important. How do they come into play when a patient walks into your clinic?

Dr. Amy McMichael:
Well, I think it comes into play in a variety of ways. One of them is that you may be seeing alopecia areata, but you may also be seeing other issues along with it. So you have to treat all of the things that you're seeing. So you may be seeing increased fragility with breakage. You may be seeing something going on the frontal hairline that looks somewhat like alopecia areata, but might not be alopecia areata and might likely be traction alopecia.

You may see something that's happening on the vertex, that's happening because there is inflammation in this area and the patient may have a form of hair loss called central centrifugal cicatricial alopecia, or CCCA, in addition to the alopecia patches that you think are very consistent with alopecia areata.

So we know that the breakage is very common with seborrheic dermatitis because people itch and scratch where they itch. And so you have hair breakage, and so you've really got this sort of, you know, stew of things. You know, you've got this melting pot of potential diseases that could all be happening in the same person at the same time.

Dr. Brett King:
So, so it's going to be more complicated. we haven't spent a whole lot of time learning about hair and hair loss disorders, across populations.

I think we, right when patients come in, we tend to immediately sort of insist that what we're looking at is a single thing and we try to make it simple and come up with simple solutions. But you're highlighting that we have to be a little bit more sophisticated and have to think just sort of more broadly about, about the patient sitting in front of us.

Dr. Amy McMichael:
One of the other things that I often teach my residents and tell my students about is nighttime hair care. One of the things that patients will often do is to wear their hair in a style at night so that it doesn't interfere with the daytime look that they have.

So they will wear a protective cap or a scarf. Sometimes they'll use satin or silk pillowcases. But one of the things that can happen is a nighttime scarf can be used, and it can be wrapped very tightly. There are also other forms of bonnets and such that will tightly wrap around the frontal and temporal hairline.

And those actually can cause what we call nocturnal traction alopecia. So it's important not to just ask what people are doing during the day, but it's also important to ask what they're doing at night. So hair care practices throughout the cycle of the day, in the hair of the patient, even what they've done as a, as a kid, is important when we see patients even in adulthood.

Dr. Brett King:
All right. So this is already a great education. we've set the stage with considerations around hair itself and differences in hair, hairstyle, hair care practices, in patients with skin of color.

And so now, let's, let's turn a little bit to the subject of this series, alopecia areata.

Can you tell us a little bit or quite specifically about the differential diagnosis of, of alopecia areata in people with skin of color? And what, what are the things that we all need to be thinking about?

Dr. Amy McMichael:
Sure. Absolutely. When I see patches, you know, at times I'm very sure that I see exclamation point hairs and I have a positive pull at

the margin, follicles are there in trichoscopic exam, I know this is alopecia areata. But at times I look and I see broken hairs, no exclamation point hairs, small patch, there are potentially excoriation on the scalp, not much redness, maybe a little subderm. And what we're looking at is either a seborrheic dermatitis with scratching or potentially trichotillo, with somebody just really going to town on their scalp. And I think at that point, you have to pull back and start asking some questions, you know, what is actually going on in this patch?

And the other thing that I can see that's patchy is discoid lesions of lupus. Now, of course, it's always great when you have all the things there, when you have hyperpigmentation, hyperkeratosis, you know, some erythema, but that's not always there. So then you start having to look for other things and definitely at that point stepping back and doing a biopsy. I like to biopsy Prove, my daily lesions, because then I can go forward and move to looking at their systemic involvement, etc.

So I think patchy stuff, you know, think about all of those things. Frontal hair loss, you know, it could be alopecia areata because we all know that alopecia areata likes to sort of move. And you know, this sort of patterns and it can be very frontally organized. But what about frontal fibrosing alopecia? And what about traction alopecia? Those are two things that, you know, really have to be ruled out.

And, you know, often times traction alopecia's so, so common, we don't have great prevalence data on that. It’s so so common, it may coexist with alopecia areata. Take two biopsies and figure out which one you're dealing with or if you have to treat both. When you're talking about vertex scalp, there may be a large patch of alopecia in that area.

Is there scarring that makes you think, oh, this is CCCA, is there peripilar halos? Is there follicular dropout? You know, positive pull test is typically not seen in CCCA. So if you have those things, you know, again, it's not, it's unclear whether you're dealing with alopecia areata or CCCA. That's when a biopsy is going to come into play.

And then, and when you talk about posterior scalp, you know, we see a lot of posterior scalp alopecia areata. We even have a fancy name for it, ophiasis pattern, but there could be other things back there, things like acne keloidalis nuchae, again, trichotillis in perfect area. People do a lot of scratching and rubbing in the posterior scalp.

So, you know, you have to sort of sort out where your alopecia areata is and where it isn't. And you have to use every tool in the toolbox to figure that out sometimes

Dr. Brett King:
You know, it's amazing because this is, this is the first conversation we've had in this series where, where the concept has come out of, right, complex alopecias, right? It's not always one thing and, and, and it can be more than one thing. And we, we can't, we can't insist that it be simple. As much as we would like to, we can't always insist that it's simple. the concept that we might have to do two biopsies in order to make two diagnoses in the same patient, but right, that's the right thing to do if that's what we need to do. The patient has come to us for answers and we're, right, we, own hair. It's up to us to spend a little more time to ask a few more questions, to evaluate the entire scalp and other hair bearing surface areas to accurately diagnose a patient, to help ultimately manage what they've come to us for help for. That was just so great to hear.

So, Dr. McMichael, how often in your practice, out of how many patients, you know, do you need to see in order to do a biopsy?

Dr. Amy McMichael:
I would say probably in my African-American patients, it would be about one out of every 20 patients with a concern for alopecia areata. So it's by far not everyone, but it is very helpful in certain circumstances. And I think that I probably am on the cutting edge of what's happening in, in, in a colored scalp. So maybe it'll be a little bit more for somebody who's not as practiced. So I just throw that out there as using a biopsy as a guide to really helping your patient get to the right, right diagnosis quickly.

Dr. Brett King:
Yeah. No, I, I actually I'm really glad that you, that you said that because, because it's really important, right? A scalp biopsy is not difficult to do and we shouldn't hesitate to do it, especially if we're going to neglect to understand that somebody has a scarring alopecia and they're not going to come back for six months.

You know, that clock is ticking and they're losing hair follicles. And I think it's really important to, to, to capture everybody to, to make it so that, you know, as few people as possible escape successful treatment. And so, so it's good to, it's good to call out that for you It might be 5%, but for the rest of us, it's okay if you're biopsing 10% or 15% or 20% of your patients to make the correct diagnosis.

Dr. Amy McMichael:
One thing we didn't mention was the fact that, lately, studies have been showing, when we look closer at prevalence, that alopecia areata is a lot more common and potentially more common in African-American patients, at least in this country, than it is in others. So I think it really is so important to recognize it and think about it and the differential, rather than assuming that somebody has tinea capitis or has a, you know, discoid lesion of lupus or something else that could be circular and very similar appearing.

And that is when we have to bring out our tools. We have to bring out our dermatoscopes. We have to bring out our biopsy. All of those things are so important in getting our patients to the right diagnosis so that we can ultimately get them to the right treatment. And even when we're discussing treatment, we can choose our treatment, you know, based upon what we see.

Dr. Brett King:
Thank you so much, Dr. McMichael, for being with us today to share everything that you know. And thank you to our listeners and we hope that this has been a very helpful presentation and discussion of alopecia areata in patients with skin of color.

Announcer:
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