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Concurrent Lichen Planopilaris and Female Androgenic Alopecia in Skin of Color: A Case Series

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ABSTRACT

Background: Trichoscopy findings can differ in the skin of color requiring a dedicated approach with adequate examination in order to ensure proper diagnosis and treatment. This case series details three cases of concurrent lichen planopilaris (LPP) and female androgenic alopecia (FAGA) in the skin of color.

Methods: Gross examination of all cases revealed mild to moderate hair density thinning of the temporal and frontal scalp. Trichoscopy was done in all three cases before biopsy. The temporal scalp of each patient showed diffuse hair follicle miniaturization with minimal terminal hairs and brown follicular halos, all findings were consistent with FAGA. However, upon inspection of the frontal scalp, each case revealed findings associated with scarring alopecia including scale, erythema, and peripilar casts in addition to the presence of follicle miniaturization.

Results: In the first two cases, two punch biopsies were taken, one from the temporal scalp and one from the frontal scalp. Temporal biopsy revealed FAGA and frontal biopsy revealed LPP arising in a background of AGA. In the third case, only the frontal scalp was biopsied, which showed LPP in a background of FAGA. All three cases received the same treatment regimen; clobetasol 0.05% solution and minoxidil 5% foam/solution topically for treatment of FAGA and monthly intralesional triamcinolone acetonide for treatment of the LPP.

Conclusion: Our report suggests the importance of total scalp dermoscopy and the need for biopsies in areas with varying dermoscopy findings as opposed to areas with the most significant hair loss.

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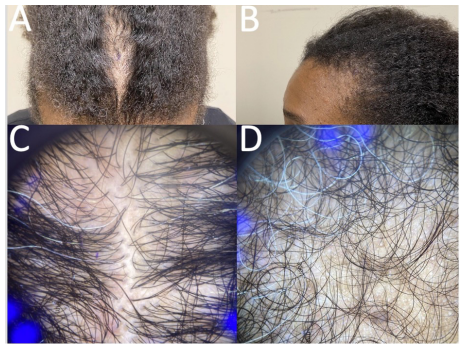
INTRODUCTION

Lichen planopilaris (LPP) is a primary scarring alopecia and a follicular version of lichen planus (LP), which can present in association with LP or more often presents alone.[1] Androgenetic alopecia is a nonscarring alopecia with a genetic predisposition that leads to pattern baldness.[2] In males, it classically begins with bitemporal thinning of the frontal scalp and can involve the vertex while women can present with vertex and frontal scalp involvement.[2] Trichoscopy, or scalp dermoscopy, findings can differ in skin of color requiring a dedicated approach to ensure adequate examination to provide proper diagnosis and treatment.[3-4] This case series details three cases of concurrent lichen planopilaris (LPP) and female androgenic alopecia (FAGA) in the skin of color.

Case 1

A 52-year-old Black female with a past medical history significant for lupus, depression, and iron deficiency anemia presented to the office with several years of hair loss and recently acquired "bald spots." Her hair loss was reported to be exacerbated by stress. She denied any scalp itching, dryness, pain, or flaking, and denied loss of hair on other parts of her body. In the past, she has had tight braids but removed them because of migraines. Examination revealed moderate thinning at the frontal scalp (Figure 1A) with trichoscopy of the region revealing perifollicular scale, mild erythema, and interruption of honeycomb pattern with the presence of vellus hairs (Figure 1C). Examination of the temporal scalp revealed mild hair density thinning with diffuse hair follicle miniaturization with the presence of pinpoint white dots and brown halos around the hair follicles (Figure 1D). Differential diagnoses included FAGA, cutaneous lupus, diffuse alopecia areata, or traction alopecia exacerbated by telogen effluvium. Due to the differences in trichoscopy findings, two 4

FIGURE 1. (A) Frontal scalp (B) Temporal scalp (C) Trichoscopy of frontal scalp (D) Trichoscopy of temporal scalp.

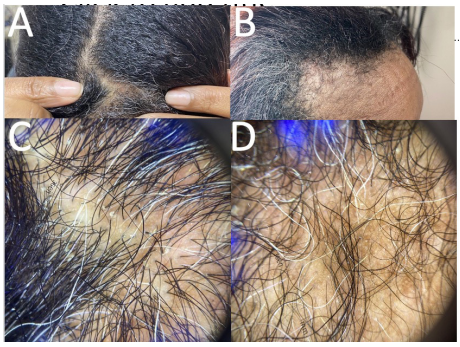


mm punch biopsies were performed; one of the left frontal scalp and one of the right temporal scalp. The left frontal scalp biopsy showed LPP. Both biopsies showed AGA. She was treated with clobetasol 0.05% solution and minoxidil 5% foam/solution for treatment of FAGA and monthly intralesional triamcinolone acetonide (TAC) for treatment of the LPP.

Case 2

A 43-year-old Black female with a past medical history of hypertension presented to the office for hair loss coinciding with cessation of oral birth control. The patient used Rogaine 2% for 2 months with improvement. She stopped relaxing her hair five years prior and has not had braids for three years. Frontal scalp revealed mild hair density thinning (Figure 2A) with trichoscopy revealing peripilar casts and scale with white blotches interrupting the honeycomb pattern with some vellus hairs present (Figure 2C). Examination of the temporal scalp revealed moderate thinning (Figure 2B), with trichoscopy revealing increased vellus hair density with pinpoint white dots and minimal scale (Figure 2D). The differential diagnosis was either FAGA, LPP, or traction alopecia exacerbated by telogen effluvium. Two 4 mm punch biopsies were taken from the left temporal scalp and the frontal mid scalp. The frontal mid-scalp biopsy suggested LPP, and both biopsies showed evidence of AGA. This patient was also treated with clobetasol 0.05% solution and minoxidil 5% foam/solution topically for FAGA and monthly intralesional TAC for the LPP.

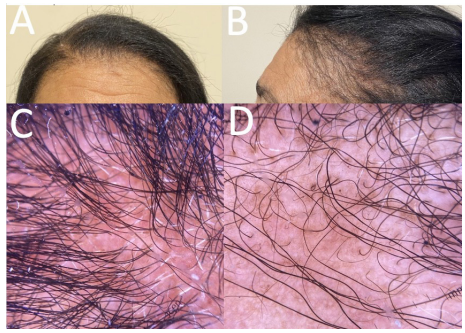
FIGURE 2. (A) Scalp Vertex (B) Temporal scalp (C) Trichoscopy of mid frontal scalp (D) Trichoscopy of temporal scalp.



Case 3

A 68-year-old Hispanic female with a history of hypertension, pre-diabetes, and GERD presented for an evaluation of her hair loss (Figures 3A-3B). Her hair loss started in 2020 after infection with COVID-19. She feels that her hair sheds easily and occasionally has pruritus on her scalp. She denies any scalp pain or dandruff. She had a negative hair pull test. On dermoscopy, she had perifollicular pallor and mild scale (Figures 3C-3D). The differential included telogen effluvium, AGA, traction alopecia, and LPP. Hair loss labs were within normal limits. A 4 mm left frontal scalp biopsy showed LPP on a background of AGA. This patient was treated with the same regimen as the first two cases.

FIGURE 3. (A) Scalp front (B) Temporal scalp (C) Trichoscopy of the frontal scalp (D) Trichoscopy of the temporal scalp.



DISCUSSION

Trichoscopy (dermoscopy) requires a methodical and dedicated approach that involves the entire scalp as different areas of the scalp can present with different findings. In LPP, the most common trichoscopy findings are perifollicular scale (hair casts) plus or minus perifollicular erythema in active disease, with areas of white dots and areas of fibrosis in end-stage disease.[1] Special considerations must be made for the recognition of these diseases in skin of color. Trichoscopy of LPP in dark scalps maintains the peripilar casts and scale with blue-grey dots in an annular pattern or target pattern.[3] AGA presents with a preserved honeycomb pattern with pinpoint white dots and sometimes with brown peripilar halos on the dark scalp.[3] As in AGA in lighter skin types, the hair density in AGA in dark scalp is associated with more than 20% vellus hair scalp involvement.[6] On trichoscopy of the temporal scalp, all of our cases show greater than 20% variability with the presence of vellus hairs. The background shows pinpoint white dots with brown halos. This should be recognized as androgenetic alopecia without much doubt. However, the frontal scalp on examination showed different trichoscopy patterns. While we still see some presence of vellus hairs and variability of hair density diameter, we also see scale and erythema as evidence of an underlying inflammatory disorder. The scale and peripilar casts should be recognized with the corresponding scarring pattern as seen with the disruption of honeycomb pattern and white patches. Without noting the other changes, the scale and casts could be mistaken for seborrheic dermatitis. This distinction is clinically important as solely treating these patients for AGA and seborrheic dermatitis could lead to irreversible progression of LPP. Of note, it is also important to remember that frontal fibrosing alopecia, which is a variant of LPP, usually involves the frontal and temporal scalp but will have peripilar casts and more prominent perifollicular erythema or violaceous color in temporal areas.

A case series of AGA with subtle LPP has been described in the context of hair transplantation. Correctly identifying LPP is an important factor in hair transplantation as it is a contraindication to the procedure.[5] While addressing the disease changes, this

case series by Baquerizo Nol et al does not address any patients of color. Our findings agree with this case series and provide examples of three cases in skin of color. While a variant of LPP mimicking AGA has been described, our case series is a different entity.[6]

Trichoscopy should be used to evaluate the total scalp. It is critical for clinicians to identify respective changes within the scalp. In Case 3, we identified similar findings on clinical and trichoscopic exams that led us to biopsy only the frontal scalp. The frontal scalp on clinical exam shows less gross hair loss on physical exam, however, trichoscopy reveals active changes within the hair follicle. The biopsy results came back with the same pathology as the first two cases. All cases were treated with the same regimen, and we saved our patient a second biopsy. Our report suggests the importance of total scalp dermoscopy and the need for biopsies in areas with varying dermoscopy findings as opposed to areas with the most significant hair loss and trichoscopic findings. We further emphasize that dermatologists must be familiar with the presentation of diseases in skin of color.

DISCLOSURES

The authors have no conflicts of interest to declare.

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