



Winter 2021
Welcome message

Happy New Year to all!

We have entered another year and I cannot believe we are still discussing Covid, though we are clearly in a better position compared to this time last year. The Omicron variant is spreading fast but hopefully proving to be a mild illness and with both our cumulative post viral and vaccine related immunity, we should be looking forward to the beginning of the end of the pandemic.

2021 has mainly been a virtual platform with the majority of us needing to learn to use Zoom or Teams (for me this was the first time!) pretty quickly as a new way of communication. The British Hair and Nail Society was no different and hosted two excellent virtual training events. Our first registrar training event on hair and nails was an astounding success. Well done to the committee hosts Leila Asfour, Sonia Sharma and Rona Applewaite! Sophie Winters has brilliantly captured the pulse of the training day and summarised it for this newsletter. Dhruv Laheru hosted the national nail education day which showcased an impressive line-up of great international speakers.

This newsletter has a series of interesting articles for you to ponder. Julian Pearce, Linda McMahon and Archana Rao have shown us that habit reversal therapy, a form of cognitive behavioural therapy, can work in trichotillomania. Prameela Talakola has written a rare case report of familial FFA—frontal fibrosing alopecia in father and son, who presented to our hair clinic. Greg Williams has really helped us understand the indications for hair transplant surgery in his excellent article. This will no doubt allow us to have a realistic dialogue with the numerous patients who enquire whether hair transplant will benefit their hair problem.

Look out for more exciting new events this year. These will be communicated to all the BHNS members by our brilliant admin Rose Wilmot. Thank you as always Rose!



Dr Anita Takewale
BHNS President

NEWS

New Members

Dr Dalia Saidely Alsaadi
Dr Sharon Crichlow
Dr Gemma Harrop
Dr Emily Hayes
Dr William Hunt
Dr Faris Kappa
Dr Ihsan Fazal
Dr Timea Kosztyuova
Dr Oluwadamilola Jagen
Dr Felipe Partarrieu-Mejias
Dr Julian Pearce
Dr Ravi Ramessur
Dr Archana Rao
Dr Nicola Salmon
Dr Sonia Sharma
Dr George Woodward

Journal Club

Many thanks to contributors of the monthly Journal Clubs. Contributors over the last 6 months include:

Dr Rhiannon Seys Llewellyn
Dr Faraz Imran

If you would like to contribute to the Journal Club please contact rose.wilmot@plymouth.ac.uk.

New BHNS Committee Members

The BHNS would like to welcome our new committee members:

Dr Donna Cummins - Treasurer
Dr Leila Asfour - Communications Lead
Dr Rona Applewaite - SAS Rep
Dr Sonia Rupal Sharma - Trainee Rep

PARTICIPANTS NEEDED FOR NEW TRIAL

Clinical trial of a new form of dithranol for treating alopecia areata

This is a Phase II, dose response clinical trial to assess the efficacy and safety of a range of doses (with placebo control) of a controlled release formulation of dithranol for the treatment of mild - moderate patchy alopecia areata (AA).

A total of 150 subjects will be treated for 6 months with clinical efficacy assessments every 2 months to assess hair regrowth (SALT score) and a subsequent follow up after a further 2 months.

Safety assessment for tolerance are also performed at these visits.

Additional assessments of Quality of Life and blood samples for inflammatory response (cytokines) will also be performed at baseline and 6 months

The aim of the study is to see how effective the new dithranol formulation is in inducing hair regrowth.

Who can take part?

Anyone:

- Age 18 or over
- With a current episode of alopecia areata lasting more than 6 months
- Able to read and write in English
- Be generally in good health and not planning to become pregnant
- Not to be using any other alopecia treatment for at least 6 weeks (or 3 months depending on medication).

For more information [please go to this web-page](#).

EVENTS

[101st Annual Meeting of the British Association of Dermatologists](#)

6-8 July 2022 - Glasgow, Scotland

The BHNS AGM will also take place on Thursday 7 July at the BAD annual meeting. All members are welcome to attend either virtually or in person. Just contact rose.wilmot@plymouth.ac.uk for more information

European Hair Research Society Events

16-18 June 2022 - St Petersburg, Russia

The next EHRS meeting will take place in the historic city of St Petersburg in Russia.

15-17 June 2023 - Sheffield, UK

The 19th EHRS meeting originally scheduled for 2020 sadly had to be postponed due to Covid-19 but will still be taking place in 2023.

World Congress for Hair Research

22-25 April 2022 - Melbourne, Australia

BHNS Trainee Travel Fellowship

The BHNS will once again be providing a Trainee Travel Fellowship for a member to attend either a hair or nail event next year. The fellowship will be for £500 and is open to all trainee members in the society.

Priority will be given to members who have successfully submitted an abstract to attend the event of their choice.

BHNS Registrar Hair and Nail Training Day Review

The very first British Hair and Nail Society (BHNS) registrar training day provided an outstanding and comprehensible overview of its complex subject matter. Often an area of the curriculum that is disappointingly neglected, the event shed light on a number of important concepts pertinent to clinical practice. From anatomy through to dermoscopy, diagnosis and management, each topic was carefully and intelligently illuminated.

Implemented in August 2021, the updated dermatology training curriculum stipulates the achievement of specialty capabilities in practice (CiPs), which describe the clinical tasks or activities that are essential to the practice of dermatology. This highlights the importance of specialist aspects of a comprehensive dermatology service, including the ability to diagnose and manage both common and rare diseases of the hair and nails, to recognise hair and nail manifestations in systemic disease, and have an understanding of dermatopathology relating to these conditions. Given the high impact sites involved and the oft emotionally-charged nature of consultations regarding areas of aesthetic concern, Dr Yusr Al-Nuami heralded a particularly poignant reminder in reference to the iconic Fleabag, 'Hair is everything'. And to our patients, it is.

Led by experts in the field, there were many notable pearls of wisdom, which have already proved invaluable on the shop floor: ciprofloxacin drops and a white wine vinegar soak for chloronychia, biotin for brittle nails, the cardinal signs of scarring alopecia, hair loss screening panels and iron optimisation for telogen effluvium; an endless wealth of knowledge. Regardless of stage in training

or number of years post-CCT, this caters to a wide audience and is not only useful for those attempting the SCE, but to anyone seeking an impactful day of education. An event not to be missed!



By Dr Sophie Winters,

Successful management of trichotillomania with habit reversal therapy in a child

A 12-year-old girl presented to dermatology with an isolated patch of hair loss which was noted by her parents a few weeks after moving to a new secondary school. Episodes of physical manipulation of her hair were noted during this period. The patient had a past history of repetitively damaging her fingernails by picking, suggestive of onychotillomania.

On examination there was evidence patchy hair loss with uneven hair lengths. Dermoscopy demonstrated decreased hair density, broken hair, trichoptilosis ("split ends") and irregular coiled hair, in keeping with trichotillomania. The diagnosis was sensitively explained to the patient and her family and she was referred to a Clinical Nurse Specialist with training in habit reversal therapy (HRT).

HRT included techniques to bring habit awareness to the patient using a tally counter over the course of five days to record episodes of hair manipulation. The patient was encouraged to write down any particular

associated triggers. At review, the patient had counted between 25 and 50 touches a day and identified periods of boredom such as watching television after school as a danger time for hair manipulation. At review, her results were discussed and techniques agreed to help minimise the habit. These included bringing her hands to her sides when she noticed herself touching her hair, clenching her fists and counting slowly to thirty, as well as encouragement of hobbies providing relaxation such as drawing at times of boredom. A follow up several months later revealed that the techniques had facilitated positive habit awareness and the measures to reduce further episodes of hair manipulation were successful. Her hair had fully re-grown with no further areas of hair loss visible and the patient was subsequently discharged.

Trichotillomania (TTM) literally means morbid craving to pull out hair. It is characterized by recurrent pulling out of one's own hair, leading to hair loss and functional impairment. Arguably within the spectrum of obsessive-compulsive disorder (OCD), TTM is thought to be largely related to anxiety disorders. Although documented in medical literature since the 19th century, it has received scant research attention. Treating trichotillomania with pharmacotherapy is complicated since there are currently no FDA-approved drugs for its treatment.

HRT is a form of cognitive behavioural therapy which has demonstrated efficacy in the management of trichotillomania as well as other body-focused repetitive behaviours. It is considered first-line treatment in all age groups for trichotillomania. Evidence is encouraging for its use in both paediatric and adult patients with randomised controlled trial data demonstrating superiority compared to placebo. In one study HRT had a 76% response at 1 and 3 months (1). Five key

concepts are central to HRT; awareness, competing responses, stimulus control, relaxation and social support (2). Awareness of the behaviour is essential for habit and trigger identification. Adults and older children may successfully associate certain thought processes or emotions preceding hair pulling-behaviours but younger patients often require parental assistance developing awareness (2). In our case, use of a tally counter aided development of awareness and allowed generation of baseline and follow-up data, which are important for generating outcome measures. Competing responses to hair manipulation can include alternative hand actions and inhibiting barriers such as wearing gloves or a hat or use of petroleum jelly on the affected area to discourage touch.

Use of innovative electronic devices can aid stimulus control, such as vibrating bracelets which are triggered when moved towards the head area for more than 3 seconds (3). These can allow enhanced monitoring of habits and complement the process of HRT. Relaxation techniques tailored to patient preference complement the process, aiming to allow a clarity of mind to aid success. Finally, social support particularly in paediatric patients is key to positively reinforce modified behavioural patterns.

Trichotillomania causes significant morbidity, impacting psychosocial development, especially in the paediatric population. Dermatologists should have an awareness of HRT and its positive role within the management of trichotillomania, such as in our case. Dermatologists can maximise patient care by extending their training to include HRT and/or foster relationships with experienced professionals in HRT such as CNS, psychologists and psychiatrists.

References

1. Rahman O, Mcguire J, Storch EA, Lewin AB. Preliminary randomized controlled trial of habit reversal training for treatment of hair pulling in youth. *J Child Adolesc Psychopharmacol*. 2017; 27: 132- 139.
2. Henkel ED, Jaquez SD, Diaz LZ. Pediatric trichotillomania: review of management. *Pediatr Dermatol*. 2019; 36: 803- 807.
3. Himle JA, Bybee D, O'Donnell LA, et al. Awareness enhancing and monitoring device plus habit reversal in the treatment of trichotillomania: An open feasibility trial. *J Obsessive Compuls Relat Disord*. 2018; 16: 14- 20.

Dr Julian Pearce, Dermatology Registrar.



Linda McMahon, Dermatology Clinical Nurse Specialist.



Dr Archana Rao, Consultant Dermatologist.



Familial FFA- a rare case of frontal fibrosing alopecia in father and son.

Frontal Fibrosing alopecia (FFA) is rare in men and there is only one other case report of familial FFA in father and son (1).

A 42 year old gentleman (figure 1a) was referred to our hair clinic for patchy hair loss. He described onset of this condition in his early 30's with patches of hair loss appearing initially on his beard area and legs for which he did try steroid cream. However, patches started appearing on his eyebrows and also side burns. He started noticing a receding hairline as well. He is otherwise fit and well, no other medical problems or regular use of sunscreens. On examination, there was frontal hair line recession with scarring fronto temporal hair loss with perifollicular scaling and skin coloured papules on his forehead, alopecia on beard area and rest of the body (figure 1b,1c,1d). Trichoscopic examination and clinical features were consistent with FFA (1e,1f). We initially treated him with topical Protopic ointment once a day along the frontal line and eyebrows and offered oral treatment with doxycycline.

While questioning about his family history, he mentioned his dad had lost body hair, facial and scalp hair like him in his 50's for which he never sought help and thought it was male pattern hair loss. This made us wonder if his dad got similar condition. We requested him to bring his dad for a clinical assessment in the subsequent visit. On examination, his dad (figure 2a) showed frontotemporal hair line recession with scarring alopecia on his fronto temporal scalp, thinned and shiny skin (figures 2b,2c,2d), hair loss of eyebrows, beard area and rest of his body. There were papules on his cheeks and forehead. Trichoscopic examination (2e,2f) and clinical appearance confirmed FFA. Other relevant examination including environmental triggers, hormonal

factors was negative. He has used sunscreens only latterly but the condition had started even before that.

We are considering testing for a genetic link in them as this pathogenesis was underexplored in men.

FFA is very rare in men, although it may be overlooked or under considered diagnosis because of its clinical similarity with androgenetic alopecia(AGA), especially in men. As mentioned in the few studies done on the clinical pattern of FFA in men (3), FFA should be considered as a diagnosis especially when there is loss of hair on the eyebrows or facial and body hair which is unseen in AGA.

There was only 1 case report of FFA and father and son¹ although a few familial FFA in men were reported in siblings or relatives, they have also other associated environmental and hormonal factors. In our case, there were no additional factors and the only link seems to be familial. Tziotzios et al reported a strong genetic link of FFA in females from their study on a huge sample (2). We feel further studies are needed to clarify the importance of genetic factors especially in men.

Figures





Figures

Figure 1d

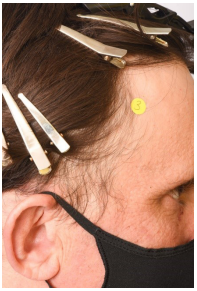


Figure 1e



Figure 1f

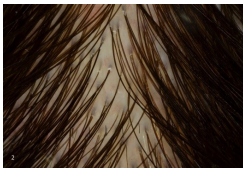


Figure 2a



Figure 2b



Figure 2c



Figure 2d



Figure 2e

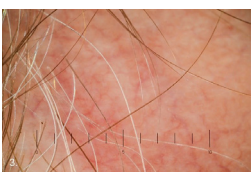
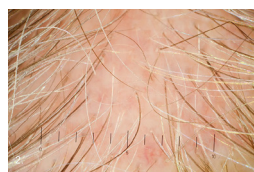


Figure 2f



References

1. Porriño-Bustamante, María & García-Lora, Elena & Buendía-Eisman, Agustín & Arias-Santiago, Salvador. (2019). Familial frontal fibrosing alopecia in two male families. *International Journal of Dermatology*. 58. 10.1111/ijd.14499.
2. Tziotzios, C., Petridis, C., Dand, N. et al. Genome-wide association study in frontal fibrosing alopecia identifies four susceptibility loci including HLA-B*07:02. *Nat Commun* 10, 1150 (2019). <https://doi.org/10.1038/s41467-019-09117-w>
3. Tolkachjov SN, Chaudhry HM, Camilleri MJ, Torgerson RR. Frontal fibrosing alopecia among men: A clinicopathologic study of 7 cases. *J Am Acad Dermatol*. 2017 Oct;77(4):683-690.e2. doi: 10.1016/j.jaad.2017.05.045. Epub 2017 Jul 14. PMID: 28716436.

By Dr Prameela Talakola



Dr Anita Takwale



Indications for hair transplant surgery

Not infrequently I get referrals from dermatologists for hair transplant surgery that are inappropriate. If the patient has been led to believe that a transplant will be possible and then I say something different, either they think I don't know what I am talking about or it reflects badly on the referring doctor. Either way, the patient invariably becomes upset – sometimes even angry or depressed.

There are many classifications of hair loss but a simple one for hair transplant surgeons to use makes the distinction between scarring alopecias and non-scarring alopecias. Scarring alopecias can be further subdivided into primary and secondary. In general, I do not perform hair transplants in primary scarring alopecias – these include the more common frontal fibrosing alopecia (FFA), lichen planopilaris (LPP) and central centrifugal cicatricial alopecia (CCCA). If a scarring alopecia has been stable for over 2 years off treatment and an absence of inflammation is proven by biopsy then, in very selected cases, I might consider a transplant. However, the patient is required to sign a disclaimer which acknowledges that the transplanted hair might not grow initially, that if the transplanted hair does grow it might not be sustained, but in the worst case scenario, that surgery might cause the disease to flare up and result in further hair loss.

On the other hand, secondary scarring alopecia from trauma, surgery and burns may be suitable for surgical hair restoration but this depends on the quality of scarring and the amount of subcutaneous tissue beneath the scar. Alopecia from radiotherapy is also treatable with hair transplant surgery.

By far the commonest request for hair transplant surgery comes from men with androgenetic alopecia. However, not all men

with male pattern hair loss are suitable. The risk of advanced hair loss needs to be balanced against the available donor hair and patient expectation. Ideally patients will be engaged with some form of hair loss prevention treatment prior to having surgery.

Female genetic hair loss is, in some cases, amenable to hair transplant surgery but requires much more extensive investigation than male genetic hair loss and there is a much wider differential diagnosis to be considered. Often women complain of a decrease in hair quality or volume rather than a decrease in hair density and there needs to be a sufficient decrease in hairs per square centimetre in order for a transplant to be technically achievable.

Traction alopecia is primarily found in women who have worn tight hairstyles or braids as well as hair extensions and weaves. It is particularly prevalent in women with Afro-textured hair and is often very suitable for hair transplant surgery. Some men also suffer from traction alopecia for similar reasons listed above but in addition Sikh men who often lose their hair in the temples and hairline from a combination of hairstyling practices that pull on the hair and wearing tight turbans. Trichotillomania can be considered as a type of traction alopecia from compulsive hair pulling. It is a difficult addiction to beat but if stopping the habitual pulling can be achieved then the hair loss can be restored with hair transplant surgery. Overplucked eyebrows are also a form of traction alopecia and these can be restored.

There are a handful of congenital hair loss conditions that are suitable for transplantation including temporal triangular alopecia, cutis aplasia and ventouse delivery trauma. Hair transplant surgery can also be used to add hair where it has never been, for



example in beard hypotrichosis and to lower congenitally high hairlines.

If in doubt about the suitability of a patient for hair transplant surgery, the best option is to talk through the case with the doctor you intend to refer to before sending a referral letter or telling the patient to make an appointment.



Key Points

Patients with the following might have hair transplant surgery declined or delayed pending dermatological investigation and treatment or input from a medical specialist:

- Uncontrolled medical conditions such as hypertension, hypothyroidism/hyperthyroidism, diabetes
- Nutritional deficiencies – zinc, iron, vitamin D
- Anticoagulation treatment
- Localised or generalised scaling scalp conditions that could be optimised – seborrheic dermatitis, psoriasis
- Scalp inflammation that is undiagnosed
- Scarring alopecias eg FFA, LPP CCCA
- Infective conditions such as folliculitis decalvans, dissecting cellulitis
- MPHL where the hair loss is rapidly progressing or there is a strong likelihood of an advanced pattern of hair loss
- FPHL where the hair loss is rapidly progressing or the donor zone is insufficient

Key Points - continued

- Telogen effluvium that has not been given adequate time to recover
- Traction alopecia where the causative practice has not ceased
- Alopecia areata
- Body dysmorphic disorder
- Unrealistic expectations

If in doubt – ask a hair transplant surgeon!

By Dr Greg Williams

