

# cutis<sup>®</sup> Photo Quiz

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A 12-year-old boy had loss of lashes on both eyes that migrated in a slow, continuous, clockwise pattern, with regrowth at previously affected sites. The patient had no other areas of hair loss.

## What is your diagnosis?

PLEASE TURN TO PAGE 19 FOR DISCUSSION

# The Diagnosis: Alopecia Areata of the Eyelashes



Alopecia areata is occasionally confined to the eyelashes<sup>1</sup> and can manifest as a partial, total, or migratory loss of the lashes. Patients often seek treatment because their eyes are no longer protected from dust and grit. Chronic conjunctivitis or corneal abrasions may occur. Eyelash alopecia areata may be associated with alopecia areata of the scalp or loss of eyebrows.<sup>2,3</sup> Nail pitting may be present, and exclamation point hairs (the base of the hair visible after shaft fracture) may be visible. In most cases, the diagnosis is made clinically, and biopsy should be reserved for exceptional cases.

Syphilis should be the main consideration in the differential diagnosis of eyelash alopecia areata. Syphilitic alopecia shares many features with alopecia areata, but the degree of clinical similarity has not been emphasized in the literature. Both conditions may be acute or subacute in onset, and both may demonstrate exclamation point hairs. I have treated patients with syphilis who had both classic moth-eaten and circumscribed-complete patterns of hair

loss, as well as a pattern that closely mimicked the ophiasis pattern seen in alopecia areata. Serologic positivity and a rapid response to penicillin in both patient and spouse confirmed the diagnosis of syphilis.

Patients with patchy hair loss should be examined for mucous patches and/or papulosquamous rash. Patients with syphilitic alopecia may demonstrate high titers of antibody, which produce false negative serologic test results for syphilis (prozone reactions). When clinical suspicion is high but serology is negative, the serum should be diluted.

The clinical similarities between some cases of syphilis and alopecia areata should not be surprising. Histologically, both conditions are characterized by lymphoid inflammation directed at the hair bulb. Although plasma cells may be present in the infiltrates of patients with syphilis, they are absent in about one third of cases. Miniaturization of hairs, catagen conversion, and pigment within fibrous tract remnants and eosinophils may be seen in both conditions.

Alopecia areata occasionally is associated with systemic disease (most often autoimmune thyroid disease or diabetes) and may occur in patients with human immunodeficiency virus infection. Patients with acquired immunodeficiency syndrome (especially

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those with severe immunosuppression) also may have elongation of the eyelashes. Paradoxically, alopecia areata, an inflammatory immune-mediated disorder, has been reported to occur simultaneously with acquired trichomegaly in patients with human immunodeficiency virus infection.<sup>4</sup>

Treatment of eyelash alopecia areata can be challenging.<sup>5</sup> Many cases do not require treatment, and decisions for treatment must be individualized. Topical steroid therapy is effective in some cases; however, the preparation should be suitable for use around the lid margin. I prefer midstrength corticosteroid preparations in a base of white petrolatum. Dexamethasone ophthalmic ointment, betamethasone valerate in a petrolatum base, and desonide in a petrolatum base may be effective. The ointment must be applied carefully to the lid margin, avoiding direct contact with the eye. Patients should be counseled about the possible adverse effects of prolonged use, which can include cataract formation and increase in intraocular pressure.

It may be advisable to seek assistance from an ophthalmologist in treating this condition. IntraleSIONal injection of triamcinolone can be effective. I use a chelazion clamp to immobilize the lid, protect the globe, and block the visual approach of the needle. This procedure should only be performed by clinicians that are skillful at administering injections near the eye. Vision loss is a rare but severe complication that can result from inadvertent injection of corticosteroid into blood vessels.<sup>6</sup>

In some cases, systemic therapy with prednisone can be effective. New treatment options such as intermittent pulse dosing of corticosteroids and the role of immune modulating drugs and immunosuppressants warrant further study.

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