Guest Editorial

Approach to Office Visits for Hair Loss in Women

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The group of women who experience hair loss and seek treatment can expand to fill the entire clinic life of a dermatologist. The typical office visit for a woman with hair loss often is challenging for both the patient and the physician due to several factors, including patient frustration with the disorder,[1] inability of the patient to understand that she can be completely healthy yet still have hair loss, inability of the patient to understand that certain forms of hair loss can stem from untreated medical concerns, and the fact that many women have a mixed form of hair loss that cannot be easily treated with one modality. For most dermatologists, the trick to handling patients with hair loss is to assess them physically and emotionally to their satisfaction without spending an inordinate amount of time on the visit. Having a very standard approach to this type of patient can help with the management of time and patient concerns.

Frustration With Hair Loss Diagnosis

By the time the patient gets to the dermatologist, she usually has researched on the Internet, seen several hairstylists, and potentially consulted more than 1 physician for diagnosis and treatment. Patient frustration stems from trying to conceal the disorder, embarrassment by the disorder, use of vitamin or other supplemental treatments without visible improvement, or even frustration at the wait for dermatologic evaluation.

In the home evaluation of this disorder by the layperson, myth is often king. Patients are told about the etiology of hair loss by well-meaning friends and the Internet, leading to further frustration and confusion. To combat the misinformation, it is important to allow the patient to give a brief history, which can be accomplished via a short survey (1 page maximum) or simple verbal questioning. A survey to ascertain the patient's history should be focused on signs and symptoms of the disorder, both currently and 6 months preceding the initiation of hair loss. If discussed verbally, the history can be obtained while the examination is performed to save time.

During the physical examination, it is important to have the patient seated in a chair that can allow the physician to examine the entire scalp, circling the patient's scalp for a full view, which puts the patient at ease because she knows you have examined everything; it also assures that you do not miss the action if it is localized. Combing through the hair with a finger followed by pull tests in all 4 quadrants of the scalp and bitemporal areas can help to diagnose telogen effluvium as the culprit (if the pull test is positive for more than 2 hairs per pull). Eyebrows, posterior auricular areas, eyelashes, and nails also should be examined. Frontal hairline and middle part examination may help to reveal frontal fibrosing hair loss or female pattern hair loss, respectively.

Once the history and examination are completed, it is critical to sit and face the patient for discussion, even if the discussion takes only 5 minutes. The patient appreciates the care you take to explain the diagnosis and treatment options. Including answers to the most commonly asked questions can shorten this part of the visit.

Most Frequently Asked Hair Loss Questions

Why do I have hair loss when no one else in my family has it?—This question is most common after a diagnosis of female pattern alopecia. Answering honestly is best. No one has the exact genetic makeup of their parents. The patient's genes have combined in this way to cause this look. We have to slow the process of miniaturization down with treatments because we cannot change the patient's genetics.

What vitamins or supplements should I take to stop my hair loss?—There are no proven vitamins for any form of hair loss at this time. If there is a measurable deficiency such as iron deficiency anemia, then replacing the iron may help some forms of hair loss, but a balanced diet and stable weight are most important for hair loss. Biotin does not affect female pattern hair loss or telogen effluvium.

Is this hair loss due to my medications?—If the medications have been stable and the hair loss started

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acutely with ongoing medication use for months or years, the medications are not to blame. When you look up medications on the Internet, they will all have some incidence of hair loss listed in the side effects but most do not cause hair loss.

Why should I begin minoxidil if I have to use it for the rest of my life?—Minoxidil solution or foam is just like any other medication that is used to treat a chronic disease. If the process is female pattern hair loss, alopecia will progress if the medication is not used. No one decides that brushing one's teeth is too cumbersome to continue; one continues to brush to keep one's teeth healthy. Likewise, one must use minoxidil to keep the hair growing maximally, at least until something better is discovered.

Health Versus Disease and Hair Loss

One caveat to remember in completely healthy patients with alopecia is that they often believe that there is some horrible disease lurking internally that is causing their hair loss, despite repeated normal laboratory results and no other symptoms of any kind. After establishing that there is no underlying systemic illness, it is important to reassure these patients and discuss and treat the real diagnosis. For most patients, the diagnosis will include telogen effluvium, female pattern hair loss, or a scarring form of hair loss.[2]

The other caveat is that many patients who have fairly substantial medical problems often come in for hair loss concerns, not realizing that flares of their systemic inflammatory conditions can cause hair shedding/telogen effluvium. Surgery for back pain, flares of rheumatoid arthritis or inflammatory bowel disease, or similar problems that are chronic and recurrent will often keep hairs shedding. For these patients, they must tend to their underlying condition, and once it is controlled for at least 6 months, the shedding will slow and stop.

Mixed Forms of Hair Loss in Women

The last recommendation is to look for more than one form of hair loss in patients who do not fit the usual pattern. In the third decade of life, women go through many health changes, such as pregnancy and deliveries, tubal ligations, starting and stopping oral contraception secondary to pregnancies or side effects, menorrhagia associated with fibroids, and extreme fluctuations in weight from the pregnancies. All of these events can wreak havoc on the hair, causing telogen effluvium in patients who are susceptible. Many times, what seems like long-term hair loss is really successive telogen effluvium events. After systemic disease is ruled out, it is helpful to count back 3 to 4 months from the initial hair loss event to see what may have been a cause of the alopecia. Often, one of these events is the culprit.

The telogen effluvium diagnosis often uncovers female pattern hair loss, bringing the patient in for shedding and thinning on the crown; it is the most common combination of hair loss and should be addressed with reassurance if the telogen is still occurring, followed by examination of the patient 6 months later for improvement. Treatment of female pattern hair loss can be started if hair loss has not started to improve by the 6-month follow-up.[3]

Conclusion

Although hair loss seems to be a daunting disorder to evaluate, breaking down the history, examination, and discussion into digestible parts makes the experience helpful for the patient and the treating physician. These patients often are the most appreciative of all our patients when we simply help them through their frustrations.

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