DX ACROSS THE SKIN COLOR SPECTRUM

Consider Cultural Practices and Barriers to Care When Treating Alopecia Areata

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Alopecia areata (AA) is a common autoimmune condition characterized by hair loss resulting from a T cell–mediated attack on the hair follicles. It manifests as nonscarring patches of hair loss on the scalp, eyebrows, eyelashes, and beard area as well as more extensive complete loss of scalp and body hair. While AA may affect individuals of any age, most patients develop their first patch(es) of hair loss during childhood.[1] The treatment landscape for AA has evolved considerably in recent years, but barriers to access to newer treatments persist.

Epidemiology

Alopecia areata is most prevalent among pediatric and adult individuals of African, Asian, or Hispanic/Latino descent.[2-4] In some studies, Black individuals had higher odds and Asian individuals had lower odds of developing AA, while other studies have reported the highest standardized prevalence among Asian individuals.[5] In the United States, AA affects about 1.47% of adults and as many as 0.11% of children.[6-8] In Black patients, AA often manifests early with a female predominance.[5]

AA frequently is associated with autoimmune comorbidities, the most common being thyroid disease.[3,5] In Black patients, AA is associated with more atopic comorbidities, including asthma, atopic dermatitis, and allergic rhinitis.[5]

Key Clinical Features

AA clinically manifests similarly across different skin tones; however, in patients with more tightly coiled or curly hair, the extent of scalp hair loss may be underestimated without a full examination. Culturally sensitive approaches to hair and scalp evaluation are essential, especially for Black women, whose hair care practices and scalp conditions may be overlooked or misunderstood during visits to evaluate hair loss. A thoughtful history and gentle examination of the hair and scalp that considers hair texture, cultural practices such as head coverings (eg, headwraps, turbans, hijabs), use of hair adornments (eg, clips, beads, bows), traditional braiding, and use of natural oils or herbal treatments, as well as styling methods including tight hairstyles, use of heat styling tools (eg, flat irons, curling irons), chemical application (eg, straighteners, hair color), and washing or styling frequency can improve diagnostic accuracy and help build trust in the patient-clinician relationship.

Classic signs of AA visualized with dermoscopy include yellow and/or black dots on the scalp and exclamation point hairs. The appearance of fine white vellus hairs within the alopecic patches also may indicate early regrowth. On scalp trichoscopy, black dots are more prominent, and yellow dots are less prominent, in individuals with darker skin tones vs lighter skin tones.[9]

Worth Noting

In addition to a full examination of the scalp, documenting the extent of hair loss using validated severity scales, including the severity of alopecia tool, AA severity index, clinician-reported outcome assessment, and patient-reported outcome measures, can standardize disease severity assessment, facilitate timely insurance or medication approvals, and support objective tracking of treatment response, which may ultimately enhance access to care.[10]

Prompt treatment of AA is essential. Not surprisingly, patients given a diagnosis of AA may experience considerable emotional and psychological distress—regardless of the extent of the loss.[11] Treatment options include mid- to high-potency topical or intralesional corticosteroids and newer and more targeted

A Alopecia areata in a young girl with a lighter skin tone. The fine white vellus hairs are signs of regrowth.

B Alopecia areata in a 49-year-old man with tightly coiled hair and darker skin tone. Coiled white hairs are noted in the alopecia patches.

Photographs courtesy of Richard P. Usatine, MD.

systemic options, including 3 Janus kinase (JAK) inhibitors—baricitinib, ritlecitinib, and deuruxolitinib—for more extensive disease.[12] Treatment with intralesional corticosteroids may cause transient hypopigmentation, which may be more noticeable in patients with darker skin tones. Delays in treatment with JAK inhibitors can lead to a less-than-optimal response. Of the 3 JAK inhibitors that are approved by the US Food and Drug Administration for AA, only ritlecitinib is approved for children 12 years and older, leaving a therapeutic gap for younger patients that often leads to uncomfortable scalp injections, delayed or no treatment, off-label use of JAK inhibitors as well as the pairing of off-label dupilumab with oral minoxidil.[12]

Based on adult data, patients with severe disease and a shorter duration of hair loss (ie, < 4 years) tend to respond better to JAK inhibitors than those experiencing hair loss for longer periods. Also, those with more severe AA tend to have poorer outcomes than those with less severe disease.[13] If treatment proves less than optimal, wigs and hair pieces may need to be considered. It is worth noting that some insurance companies will cover the cost of wigs for patients when prescribed as cranial prostheses.

Health Disparity Highlight

Health disparities in AA can be influenced by socioeconomic status and access to care. Patients from lower-income backgrounds often face barriers to accessing dermatologic care and treatments such as JAK inhibitors, which may remain inaccessible due to high costs and insurance limitations.[14] These barriers can intersect with other factors such as age, sex, and race, potentially exacerbating disparities. Women with skin of color in underserved communities may experience delayed diagnosis, limited treatment options, and greater psychosocial distress from hair loss.[14] Addressing these inequities requires advocacy, education for both patients and clinicians, and improved access to treatment to ensure comprehensive care for all patients.

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