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Short Communication

Lichen Planopilaris: An Unusual Presentation of Hair Loss

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ABSTRACT

Lichen Planopilaris (LPP), a follicular form of lichen planus, is a rare inflammatory lymphocyte-mediated disorder that selectively involves hair follicles. LPP leads to follicular destruction and, consequently, cicatricial alopecia. It frequently occurs on the vertex, but any region of the scalp can be involved. Although non-inflammatory body hair loss has been described, mainly in association with LPP variants such as Frontal Fibrosing Alopecia (FFA) and Lassueur-Graham-Little-Piccardi Syndrome (LGLPS), inflammatory alopecic patches as seen on the scalp seem to be an uncommon finding on other parts of the body.

Keywords: Lichen planopilaris; Hair follicular; Hair loss

DESCRIPTION

Lichen planopilaris is a rare inflammatory condition that results in patchy progressive permanent hair loss mainly on the scalp. Several forms are recognised:

- Classic lichen planopilaris, also known as follicular lichen planus
- Frontal fibrosing alopecia
- Graham little syndrome.

Lichen planopilaris usually affects young adult women, although the age range is wide and it also affects men. It commonly develops in association with lichen planus affecting the skin, mucosa and nails. The cause of lichen planopilaris is unknown. Although lichen planopilaris is rare, it is one of the common causes of scarring hair loss of the scalp.

Lichen planopilaris typically presents as smooth white patches of scalp hair loss. No hair follicle openings can be seen in the areas of hair loss [1]. Scale and redness surround each hair follicle at the edges of these patches, which may be spiny on palpation. Hairs can be easily pulled out. It is multifocal and small areas may merge to form larger irregular areas. Common sites of involvement are the sides, front and lower back of the scalp. Lichen planopilaris is usually slowly progressive. Diffuse hair loss is uncommon.

Symptoms are often absent, but they may include:

- Itch
- Pain
- Tenderness
- Discomfort
- Burning.

Lichen planopilaris is suspected on the clinical presentation and careful examination of the mouth, nails and skin for evidence of lichen planus elsewhere. Trichoscopy reveals absent follicles, white dots, tubular perifollicular scale and perifollicular erythema. The diagnosis may be confirmed on a scalp biopsy that includes hairs with surrounding redness and scale the edge of an area of hair loss. Lichen planopilaris is an example of a primary lymphocytic folliculitis. However, it is not always possible to make a diagnosis on biopsy. Biopsy from an already scarred area of hair loss is unhelpful. Where there is only patchy scarring hair loss and no evidence of inflammation the diagnosis may not be able to be confirmed [2].

Treatment should be sought and provided early as no treatment recovers hairs that have been lost and replaced by scarring. The aim of treatment is to slow the progression of the disease and relieve symptoms. Hair loss may continue, although at a slower rate.

Anti-inflammatory treatment options include:

- Corticosteroids-potent topical, intralesional, oral
- Topical tacrolimus
- Hydroxychloroquine
- Tetracycline eg doxycycline
- Acitretin
- Methotrexate
- Ciclosporin

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- Mycophenolate mofetil
- Pioglitazone (an oral PPAR-γ agonist).

Response to treatment is variable and some published studies contradict others as to the efficacy. The best patients can expect is to stop the progression of hair loss and to minimise scalp discomfort [3].

A management protocol was suggested by Mirmirani et al. in 2003:

- Make a diagnosis of lichen planopilaris clinically and with a scalp biopsy.
- The severity of symptoms, the extent of hair loss, and presence of disease activity are documented at each visit, approximately every 3 months.
- Oral hydroxychloroquine (usually 200 mg twice daily) is started after appropriate laboratory tests and eye check if the patient is symptomatic, has progressive hair loss or signs of active disease.
- Intralesional and potent topical corticosteroids may also be used.
- After 2-4 months, hydroxychloroquine is changed to ciclosporin (3-5 mg/kg/d) if symptoms continue, the extent of hair loss progresses, or there are clinical signs of disease activity. Ciclosporin is used according to the ciclosporin consensus guidelines [4,5].

CONCLUSION

Since 2009, there have been several reports of the use of the antidiabetic agent pioglitazone (off-label) for the treatment of lichen planopilaris. Its efficacy has varied; up to 50%-70% of patients have reduced symptoms, inflammation, and disease progression. Side effects include ankle swelling and weight gain. Camouflage with careful hair styling and hair colouring. Hairpieces may be required for areas of permanent hair loss.Surgery such as scalp reduction and hair transplantation has been used for end-stage disease with large areas of scarring but is not always successful.

REFERENCES

1. Cevasco NC, Bergfeld WF, Remzi BK, de Knott HR. A case-series of 29 patients with lichen planopilaris: The Cleveland Clinic Foundation experience on evaluation, diagnosis, and treatment. J Am Acad Dermatol. 2007;57:47-53.
2. Babahosseini H, Tavakolpour S, Mahmoudi H, Balighi K, Teimourpour A, Ghodsi SZ, et al. Lichen planopilaris: Retrospective study on the characteristics and treatment of 291 patients. J Dermatol Treat. 2019.
3. Errichetti E, Figini M, Croatto M, Stinco G. Therapeutic management of classic lichen planopilaris: A systematic review. Clin Cosmet Investig Dermatol. 2018;11:91.
4. Kang H, Alzolibani AA, Otberg N, Shapiro J. Lichen planopilaris. Dermatol Ther. 2008;21:249-56.
5. Yang CC, Khanna T, Sallee B, Christiano AM, Bordone LA. Tofacitinib for the treatment of lichen planopilaris: A case series. Dermatol Ther. 2018;31:e12656.