Focus on Sciences **Case Report**

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Trichotilomania and Request for Hair Transplantation

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Abstract

Introduction: Trichotillomania (TTM) is a type of impulse control disorder with chronic hair pulling. It effects on behavior, feelings, thoughts and quality of life.
Case Presentation: The patient is a 28 year-old single woman that was referred to hair transplantation. She was worried about her appearance, cosmetic problems and marriage. The physician noticed that she is a patient with trichotilomania type of impulse control disorder. After confirming the diagnosis of trichotillomonia by a psychiatrist, pharmacotherapy begun with Rispridone 1 mg at night, Fluvoxamine 50 mg/daily and Clomipramine 5 mg at night. Over nine months of treatment there were significant reductions in hair pulling. She was followed up and finally, the response was acceptable.
Conclusions: TTM is a poorly understood disorder that requires more studies. Despite what we know about TTM, those with the disorder report not receiving enough information for diagnose and treatment. However, the information presented in this paper can help us to prevent this disorder, reduceing the prevalence and selecting the appropriate treatment.

INTRODUCTION

Trichotillomania (TTM) is an impulse control chronic behavioral disorder [1], characterized by the recurrent compulsive hair pulling from different parts of the body which can cause tension relief during the act [2] and it may be associated with major functional impairments and psychiatric comorbidities as well as infections or skin diseases in the hair pulling areas [3]. Some patients eat the hair after pulling, which can cause masses, called trichobezoar [4, 5]. Its prevalence is below 1% [6]. Trichotillomania is diagnosed in all age and gender groups; with a notable onset peak at 12–13 [7]. Generally, it is a female dominant disorder. The exact etiology is unknown, but it is likely that multiple genes confer to trichotillomania, because it may be more likely happens in twins and the members of the families with a past history of trichotillomania [8]. It may be difficult to treat and its treatment usually consists of both pharmacotherapy and psychotherapy [9].

CASE PRESENTATION

The patient is a 28 year-old single woman that was referred the hair transplantation clinic because of the long term, treatment resistant, scalp alopecia (Fig 1), But At the time the physician noticed that she is a patient with trichotilomania type of impulse control disorder, and referred her to psychologist but although She denied her behavioral problem the dermatologist started Clomipramine 10 mg at bedtime and Fluoxetine 20 mg /daily and referred her to us.
When she attended in our clinic she covered her head by a hat, without that, the patient's appearance was notable for total alopecia and the lack of both eyebrows. She was depressed with

motor tic in the form of eye blinking and worried about her appearance, cosmetic problems and decision for marriage. She reported a 4 year history of compulsive hair pulling, restricted to the scalp and eyebrows. She had the history of whole life anxiety disorder too. The Symptoms first begun 4 years ago when she had severe stresses about her future life, marriage and the fear of remaining alone, and after that, symptoms flared times and times by increasing life stressors for example during educational period. When the first symptoms begun, she was ashamed of that, so she referred to a dermatologist and denied that her hair loss was due to such behavior. She got different local and oral drugs but because of the treatment failure she was referred to hair transplantation clinic. During this time she had lower life stressors so after a short time of local treatment she exhibited hairs of differing lengths; some were broken hairs with blunt ends, some new growth with tapered ends, and some broken mid-shaft [10]. She denied any other medical problems. She was from a low socioeconomic family and there was a history of obsessive compulsive disorder in her first degree family. After establishing the diagnosis of trichotillomonia, pharmacotherapy begun with Rispridone 1 mg at night, Fluvoxamine 50 mg/daily and Clomipramine 5 mg at night. Over nine months of treatment there were significant reductions in hair pulling (Fig 2).

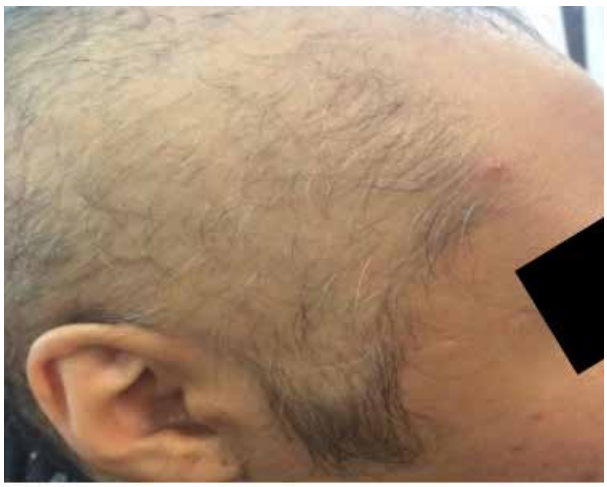

Figure 1: The Patient with Trichotilomania. Extensive Tonsure Pattern, Severe form Involving the Entire Scalp Sparing the Hair at the Marginal Zone and Eyebrows (Before Treatment)

Figure 2: The Patient with Trichotilomania. (After Psychopharmacotherapy)

DISCUSSION

Good clinical practice begins with accurate assessment for reaching true diagnoses, then planning for treatment and finally assessing changes in severity of symptoms [11]. Assessment of TTM needs gathering some information from different sources by a well-established interview performed by a psychiatrist. Our psychiatrist similarly tried to assess patient's symptoms and its severity, functional impairments, comorbiditis and differential diagnosis all based on DSM-5 criteria. Then we tried to tailor a treatment for her and assessed the patient's symptoms after psychopharmacotherapy. A 28 year old woman was referred to our outpatient clinic of psychology in Yazd medical university, reporting a 4 year history of compulsive hair pulling, restricted to the scalp and eyebrows. She had the history of whole life anxiety disorder and depression too. Instead of referring to psychiatrist, she was referred to dermatologist since

She was ashamed of declaring her behavioral problem. As she denied her problem her dermatologist just used skip local and oral skin drugs to treat her and at last because of the treatment resistance referred her to the hair transplantation clinic. This patient is diagnosed with trichotillomonia, because of the vast hair pulling area consist of the total region of scalp and both eyebrows and, 4 years of attempts to deny her behavioral problem and going to the dermatologist to seek treatment instead of the psychologist. In this case after Psychopharmacotherapy the patient was re-assessed. One objective and practical method of assessing the severity of trichotillomonia over the time is the use of photographs [11]. We snapped shot the patients' primary pulling sites, before psychopharmacotherapy and repeated again nine month after the treatment, providing an objective way of assessing the treatment success. While such patients should usually attend psychological clinics in the first step,but sometimes these patients will refuse a psychiatric referral because either they think, there is societal stigma associated with psychiatric illness or they do not believe in their psychiatric nature of disorder [12]. Therefore, it is essential for dermatologists to understand the common reasons of psychodermatological cases for example depression, anxiety, delusions, and obsessive-compulsive disorder [12]. And refer these patients to psychiatrists or other mental health care professionals.

The most common approach includes combination of pharmacotherapy and psychotherapy. Choice of the drugs in adults are SSRIs [13]. Clomipramine, has shown moderate effectiveness over placebo, N-acetylcysteine (NAC) has strongest empirical support in adults with TTM [12]. Psychotherapy in adults, adolescents and children consist of A wide variety of methods, including cognitive and behavioral therapies, supportive counseling, support groups, and hypnosis [14]. This paper is reported a patient with trichotillomonia, because of the vast hair pulling area consist of the total region of scalp and both eyebrows and, 4 years of her attempts to deny her behavioral problem and going to the dermatologist to seek treatment instead of the psychologist.

CONCLUSIONS

A case with trichotilomania may refer for hair transplantation so dermatologists should always be ready for referring them for psychotherapy. Whenever it is diagnosed, consultation with a psychiatrist about treatment of trichotilomania is necessary.

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CONFLICTS OF INTEREST

There is no conflicts of interest to declare.

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AUTHORS' CONTRIBUTION

This work was carried out in collaboration between all authors.

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