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*Case Report*

## Is Alopecia Always Areata?

Antonio Iannone<sup>1</sup>

<sup>1</sup>*Pediatrician, ASST Valtellina ed Alto Lario, Sondrio, Italy*

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### KEYWORDS

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*Trichotillomania,  
Impulse control disorder,  
Psychiatric disorder,  
Alopecia areata,  
Congenital triangular alopecia,  
Tinea capitis,  
Androgenetic alopecia,  
Dermoscopy,  
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### ABSTRACT

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We report the case of a 6-year-old child presenting with alopecia in the right frontotemporal region. Dermoscopic examination revealed broken hairs at varying lengths and the presence of intact hairs within the area of alopecia, which exhibited a markedly irregular shape. The main clinical and dermoscopic features of alopecia patterns relevant to the differential diagnosis are discussed.

### CORRESPONDING AUTHOR

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Antonio Iannone,  
Pediatrician,  
ASST Valtellina ed Alto Lario,  
Sondrio, Italy  
e-mail: iannoneant.dott@tiscali.it

## Introduction

Trichotillomania, also called hair-pulling disorder, is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as an obsessive-compulsive-

ve or related disorder in which subjects recurrently pull out hair from any region of their body, resulting in hair loss (1).

## Case Report

A 6-year-old boy presented with an irregularly shaped area of hair thinning in the right frontotemporal region. Hairs of varying lengths were visible, with no surface skin alterations. Trichoscopic examination revealed hairs broken at different lengths, intact hairs within the

affected area, and follicular hair residues (“black dots”) (Fig.1, 2).

The clinical and trichoscopic findings were characteristic of trichotillomania.



**Fig. 1.** Right fronto-temporal alopecia.



**Fig. 2.** Trichoscopy: no surface alterations, hair broken at different heights, intact hair inside the patch, follicular hair residues.

## Discussion

Trichotillomania is an obsessive-compulsive disorder that clinically presents with single or multiple patches of alopecia with irregular or bizarre shapes. These are most commonly located in the frontoparietal region, but can also affect the eyebrows, upper eyelashes, and pubic area. The presence of hairs broken at different lengths is a hallmark of the condition. It predominantly affects school-age children and is more frequent in fe-

males. Parents often have difficulty accepting the diagnosis.

On trichoscopy, the most specific and suggestive features include hairs broken at various lengths, trichoptilosis (split ends), hook hairs (proximally twisted and contracted hairs with irregular shapes), black dots (follicular hair residues), and very short broken hairs with variable diameter, shape, and distribution (2).

## Differential Diagnosis

Trichotillomania must be distinguished from several other causes of pediatric alopecia, including (Tab. I):

- **Congenital triangular alopecia**, often present at birth but sometimes not noticed until the child is 3-4 years old. It is easily recognized clinically and presents as a

triangular patch of hair thinning with the apex pointing upward toward the vertex, although the shape may also be rhomboid, lanceolate, or oval. It is most frequently localized in the temporo-parietal area, usually unilaterally, and more rarely bilaterally or in the occipital

region.

Trichoscopy shows hairs of varying lengths, fine and soft, often described as “vellus” hairs, with no signs of inflammation on the underlying scalp. Parents should be reassured of its benign and non-progressive nature, and no treatment is necessary (3, 4);

- **Tinea capitis** typically presents with one or more round patches of varying size, erythematous and scaly, with surface alterations such as redness, scaling, and crusts, along with broken hairs.

Diagnosis is clinical; fungal culture may be helpful, although trichoscopy is not strictly required. When performed, it may reveal characteristic features such as Morse code hairs, comma hairs, corkscrew hairs, and

hair casts (peripilar sleeves), as well as black dots (5, 6);

- **Androgenetic alopecia** is characterized by progressive thinning of the hair, primarily in the frontal and vertex regions. There are no surface changes, no broken hairs, and no exclamation mark hairs. The most important diagnostic feature is a variation in hair shaft diameter greater than 20% (miniaturization > 20%);

- **Alopecia areata** can sometimes be difficult to distinguish from trichotillomania. It presents with hairs broken at the base but typically all at the same level. Trichoscopy reveals follicular residues (black dots) and the pathognomonic “exclamation mark hairs” (Table II).

**Table I.** Different types of alopecia and their dermoscopic features.



**Table II.** Differences Between Trichotillomania and Alopecia Areata.

Trichotillomania	Alopecia Areata
Irregular patch	Rounded patch
<ul style="list-style-type: none"> <li>Hairs broken at different lengths</li> <li>Intact hairs within the patch</li> <li>Follicular hair residues (Black dots)</li> <li>Exclamation mark hairs absent</li> </ul>	<ul style="list-style-type: none"> <li>Broken hairs</li> <li>No intact hairs within the patch</li> <li>Exclamation mark hairs present</li> <li>Follicular hair residues (Black dots)</li> <li>Yellow dots (chronic phase)</li> </ul>

### Conclusion

Clinical observation, supported by trichoscopy, is an essential tool for distinguishing trichotillomania from other forms of non-scarring alopecia, such as alopecia areata or scalp infections.

In this context, the pediatrician plays a central role,

often representing the first point of contact for the patient and their family. It is therefore crucial that pediatricians are able to recognize early clinical and behavioral signs of trichotillomania.

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