CLINICAL INSIGHTS

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Implementing Topical Therapy for Female Pattern Hair Loss

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Female pattern hair loss (FPHL) can be distressing and frustrating for patients, and management can be a challenge for clinicians, as well. Previous installments of this series have reviewed the diagnosis and treatment of FPHL. Here we'll review some key points on diagnosis and patient counseling and discuss successful implementation of topical drug treatment for FPHL.

DIAGNOSTIC RECAP AND TIPS

Patient counseling and questioning are key in the diagnosis and management of female hair loss. You cannot assess and treat hair loss as a "by the way" patient complaint. Schedule a visit just to deal with the patient's hair loss and associated concerns.

During the exam, start by asking female patients whether they are thinning or shedding, and for how long. Patients who complain of shedding for less than six months may have either telogen effluvium, early FPHL, or breakage due to overprocessing. Patients who complain of thinning over their scalp or a decrease in the size of their ponytail for more than a year usually have FPHL.

Family history of hair loss is telling. Many patients will only inform you about their same-sex relatives, so ask about the opposite sex as well. For instance, for a young woman who is thinning in her teens, it is essential to know that her father had gone bald in his 20s. Likewise, if a peri-menopausal woman with a complicated history tells you her twin sister wears a wig, this would help you diagnose her and save time during the interview.

Physical examination is important. Female pattern hair thinning appears as a localized thinning in the frontal one-third to two-thirds of the scalp. It can appear at any age and is polygenic—coming from an assortment of ancestors. The frontal hairline remains intact, but the issue for most women is the loss of density and the resultant 'see through' effect. Clinically this thinning has been described as either a round or oval-shaped thinning (Ludwig I-III)[1] or a Christmas-tree distribution with frontal accentuation.[2] Other women can have diffuse thinning all over the scalp; a minority may have the temporal recession typical of male pattern thinning. If there is evidence of perifollicular erythema or shiny, irregular patches of alopecia, a cicatricial alopecia may be present and would require biopsy (beyond the scope of this discussion).[3]

Dermoscopy can demonstrate the presence of miniaturized follicles in FPHL.[4] Women with normal hair will have the appearance of Figure 1. However in women with FPHL, there can be a wide variation in the caliber of the hairs as seen in Figure 2. Thick, terminal hairs are replaced with finer, thinner versions of themselves. Women with early thinning may have only a few miniaturized hairs, but women with advanced thinning may have a majority of miniaturized hairs or even empty follicles on dermoscopy. Physicians who are new to dermoscopy may perform a 4mm punch biopsy to support their findings.

Use of a photographic system, such as the Canfield Dermscope® with the iPhone, to take microscopic images of the scalp during the examination, supports patient educationi-

Figure 1: Normal scalp on dermoscopy: notice healthy groups of one to four hair follicular units.

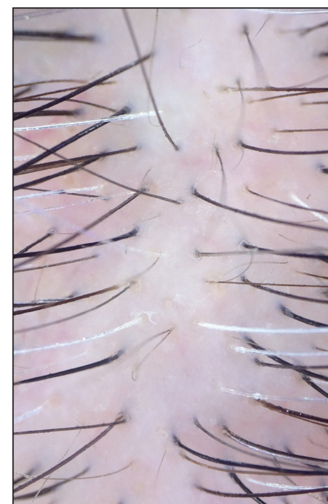

Figure 2: FPHL on dermoscopy: Thick terminal hairs interspersed with finer, thinner hairs, in smaller follicular groupings.

and counseling. Use the photos to educate patients and guide conversation.

Remember that most women are distressed by their hair loss and feel panicked because they believe it is only a short time before they will go bald. Some doctors tell women they have male pattern baldness, which only increases anxiety. Reassure patients that they are not men, and that they will not go bald.

INITIATING TOPICAL TREATMENT

Previous installments in this series have reviewed options for management of FPHL. It is imperative to explain to patients that topical minoxidil is the only FDA approved medical therapy for women with hair thinning. It is available over the counter. Its use in treating hair loss was discovered serendipitously after patients treated with oral minoxidil for recalcitrant hypertension grew new hair. For women, it has only been available as a 2% solution for twice daily use, but Rogaine 5% minoxidil foam was recently FDA approved for once daily use in women.[5] Patients are instructed to use this directly on the scalp, not the hair, for at least six months before expecting noticeable results. For some patients, there is obvious regrowth (Figure 3b; 4b, courtesy of Johnson & Johnson) but for others there may only be a stabilization of the thinning process. Patients should understand that even the latter is helpful if it prevents ongoing thinning.

Patients must understand that results are not immediate and that the use of minoxidil requires long-term commitment. This will help set the stage for long-term adherence. As a once-a-day treatment that can be used in conjunction with most styling products and practices, the new 5% foam formulation of minoxidil is expected to increase compliance and decrease confusion. Reiterate that continuous use of minoxidil will be needed for maintenance of effect. Patients should know that temporary discontinuation of therapy—or even a few missed applications—will not not cause worsening of hair loss. However patients would eventually lose any new hair growth if they stopped treatment altogether.

Side effects of minoxidil may include headache or a worsening of migraines due to the vasodilatory effect. Women who have unwanted facial hair should be warned that they may see a thickening or darkening of this hair, especially if they use the higher (5%) strength more than once daily. For most women, it is of no consequence. They may already have used laser hair removal, tweezing, shaving, or topical depilatories. They may also use topical eflornithine hydrochloride (Vaniqa®) cream to gradually shrink and soften these hairs.

Additional or alternative treatment options for FPHL include oral spironolactone, low-level laser therapy (some in-office and at-home devices are FDA cleared for hair loss), and oral finasteride (pregnancy category X). Spironolactone is used off-label for hair loss and can be used in conjunction with topical minoxidil. Finasteride is FDA approved for hair loss in men only, and should not be used in women of childbearing age due to risk of birth defects.

Poor nutrition and the presence of stress do not "cause" FPHL, but they can exacerbate it. Patients may be advised to attempt to reduce stress—which may be challenging. Those with poor diets can be counseled on nutritional needs and may be offered supplements. Some promising supplements are marketed to support hair growth, though none are rigorously studied or FDA cleared.

The photos of patients below demonstrate the potential benefit of topical minoxidil for treatment of FPHL (courtesy of Johnson & Johnson). ■

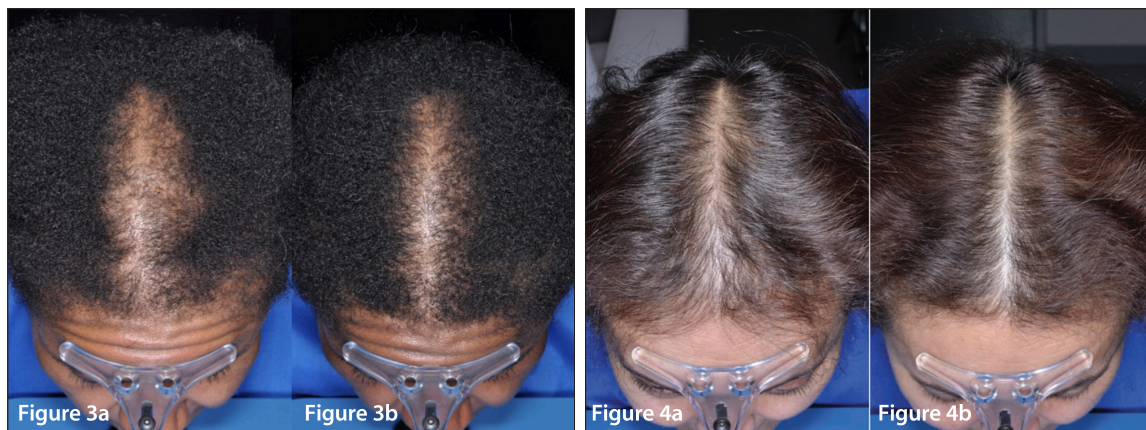

Figure 3a Figure 3b Figure 4a Figure 4b

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