Skin Appendage Disord 2016;2:97–99
DOI: 10.1159/000449229**Isolated Body Hair Loss: An Unusual Presentation of Lichen Planopilaris**Damia L. Vendramini^a, Bruno R.L. Silveira^a, Bruna Duque-Estrada^a, Ana Letícia Boff^b, Celso Tavares Sodré^a, Rodrigo Pirmez^a^aDermatology Department, Instituto de Dermatologia Professor Rubem David Azuly, Santa Casa de Misericórdia do Rio de Janeiro, Rio de Janeiro, and ^bDermatology Department, Santa Casa de Misericórdia de Porto Alegre, Rio Grande do Sul, Brasil*Key Words*

Lichen planopilaris · Alopecia · Hair loss · Trichoscopy · Dermoscopy

Dear Editor,

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 [1]. It frequently occurs on the

vertex, but any region of the scalp can be involved [2]. Although noninflammatory 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 [3]. We report a case of a 38-year-old male presenting with scarring body hair loss as the sole manifestation of LPP.

A 38-year-old male patient presented to our hair clinic with a 2-year history of progressive body hair loss. It had started with an isolated patch of alopecia on his right lower limb. Gradually, he developed new areas of alopecia on his left limb and, after 1 year, he also noticed lesions on the upper limbs. The patient reported that intense itching preceded hair loss. Previous treatments included multiple topical antifungal agents, which were all ineffective. Physical examination revealed well-demarcated extensive areas of alopecia on the limbs (fig. 1) with preserved sensory perception. Dermoscopy of the hair-bearing margins showed perifollicular erythema, discrete perifollicular scaling and some broken hairs (fig. 2). On scalp examination, there were only signs of early androgenetic alopecia on the vertex region, without clinical or dermoscopic signs of inflammation. The eyebrows, axillary and pubic regions were unaffected. Additional laboratory examinations including treponemal tests, thyroid function and antinuclear antibodies were all normal. Dermosco-

Fig. 1. Clinical images showing alopecic patches on the thighs (a), legs (b) and arms (c). a Pronounced perifollicular erythema can be seen. c There is a marked contrast between alopecic and normal hairy areas.

Fig. 2. Dermoscopy of the hair-bearing margins shows perifollicular erythema, discrete perifollicular scaling and some broken hairs. $\times 20$. Picture taken with Fotofinder Handyscope® Teachscreen Software, Bad Birnbach, Germany.

Fig. 3. Horizontal section of a punch biopsy specimen at the level of the upper follicles showing perifollicular lichenoid inflammatory infiltrate and concentric fibrosis. Hematoxylin and eosin. $\times 10$.

py-guided punch biopsy of an area showing perifollicular erythema and scaling on the right arm revealed perifollicular lichenoid inflammation and scarring, confirming the clinical diagnosis of LPP (fig. 3). At first, treatment with doxycycline 100 mg/day and topical clobetasol 3 times a week on the hair-bearing margins were prescribed. After 3 months, the patient reported resolution of symptoms (pruritus). As expected, hair regrowth was not observed. Due to the great extent of body hair loss and its scarring nature, the need of therapy was discussed with the patient, who opted for no treatment. However, follow-up consultations are scheduled every 3 months, in order to monitor symptoms and scalp hair.

Although classic LPP can occur on any part of the scalp, it usually affects the vertex region, typically presenting as patches of scarring alopecia with inflammatory signs on the hair-bearing margins, such as perifollicular erythema and scaling. Pain, itching or burning sensations may be associated and indicate disease activity [2, 4]. The possibility of body hair involvement is well established in some variants of LPP, such as FFA and LGLPS. FFA is mainly characterized by progressive recession of the frontotemporal hairline with eyebrow involvement; noninflammatory body hair loss is reported in up to 24% of FFA patients [5, 6]. In LGLPS, patches of scarring hair loss on the scalp and disseminated follicular hyperkeratosis are classically described in association with noncicatricial alopecia of the axillary and pubic regions [1, 7]. However, in classic LPP, body hair involvement has been poorly described. Even though it is mentioned in the literature [1], a clear

description of its nature (scarring vs. nonscarring), clinical presentation (inflammatory vs. noninflammatory) and incidence seem to be lacking. Furthermore, in our literature review, we were unable to find cases similar to that described herein, in which inflammatory patches of scarring alopecia on the limbs were the sole manifestation of LPP.

Differentials that should be considered in patients presenting with body hair loss include, among many others, alopecia areata, hypothyroidism, mycosis fungoides, syphilis and leprosy [8]. However, epidemiological history, clinical presentation and dermoscopic findings pointed to the diagnosis of LPP, which was confirmed through histopathology [9, 10].

In conclusion, we present an unusual case of LPP presenting with isolated patchy alopecia on the limbs. The delay to diagnosis in this case highlights the need for strong clinical suspicion and reinforces our recommendation to consider LPP as a differential diagnosis in patients with body hair loss.

Statement of Ethics

The patient's consent has been obtained.

Disclosure Statement

The authors declare no conflicts of interest. There were no funding sources.

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