Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Dermatology pre-referral guidelines – alopecia areata

Fiona Stanley Hospital Dermatology

Disclaimer

These guidelines have been produced to guide clinical decision making for general practitioners (GPs). They are not strict protocols. Clinical common-sense should be applied at all times. These clinical guidelines should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient. Clinicians should also consider the local skill level available and their local area policies before following any guideline.

Introduction

Alopecia areata is an autoimmune disease where immune cells attack hair follicles resulting in non-scarring hair loss. This can be a localised patch, or very widespread (alopecia totalis where all the hair on the head is lost or alopecia universalis where all the hair on the body is lost). 80% of cases present before the age of 40. The environmental trigger of the autoimmune disease can be trauma, hormonal change, viral infection and physical or emotional stress. Many patients don't have any symptoms, but some complain of burning pain in the scalp.

Diagnosis is clinical, but trichoscopy can help (exclamation mark hairs can be seen where the hair is tapered or broken with a club-shaped root). It is important to review eyebrows, eyelashes, and pubic hair to exclude more severe types of hair loss. Nails can also be affected with pitting and ridging. Differential diagnoses include tinea capitis, trichotillosis (compulsive hair picking) and other causes of diffuse hair loss (iron deficiency, lupus, syphilis, zinc deficiency, thyroid disease).

The natural history of 50% of cases is that the hair regrows without any treatment within six months. However, one third of patients with alopecia areata will have ongoing hair loss. A number of treatments can induce hair regrowth in alopecia areata but do not change the course of the underlying disease.

Pre-referral management

First line treatment

- Potent topical corticosteroids such as betamethasone dipropionate 0.05% (lotion, cream or ointment) are typically used to settle inflammation and induce hair re-growth. The lotion is not on the PBS so Mometasone furoate 0.1% lotion may be preferred. Generally, 2-4 months is required until regrowth occurs.
- Once hair is regrowing topical steroids can be ceased, and Minoxidil 5% foam can be used off-label to prolong the anagen growth phase and promote hair growth.

Other considerations

- Consider screening for other autoimmune disorders.
- Consider counselling if significant psychosocial impact.
- There is significant evidence of suicide risk in adolescents with acute alopecia areata, especially boys.
- More severe, cosmetically bothersome disease is more concerning than a single patch.

When to refer

- Rapidly progressive alopecia areata.
- Failure to respond to conventional therapy.
- Associated significant psychosocial impact.

Essential information to include in your referral

- Duration and severity of alopecia areata.
- Types of treatment used in the past and current treatments.
- Baseline bloods including: coeliac serology, ANA, Thyroid function and antibodies, B12, iron studies, zinc, syphilis serology, hair pull and scraping for fungal microscopy and culture if appropriate.

Useful resources

- https://dermnetnz.org/topics/alopecia-areata - Dermnet
- https://www.dermcoll.edu.au/atoz/alopecia-areata-2/ - The Australasian College of Dermatologists

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Compiled: Department, Fiona Stanley Fremantle Hospitals Group, May 2025, Review: May 2028