key points

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Alopecia affects up to 50% of men and women at some time in their lives. In primary care the first step is to establish whether hair loss is focal or diffuse and if focal whether it is scarring or non scarring. It is usually possible to establish the pattern of hair loss from a combination of the history and clinical examination. Dermatoscopic examination and pull testing can be useful in confirming the diagnosis. If hair loss is accompanied by scaling or significant inflammation it is important to exclude infective causes by mycology and testing for bacteria. Histological examination with a skin biopsy is sometimes necessary.

Androgenetic alopecia is the most common form of alopecia and has a typical male and female pattern. Women present with hair thinning over the central area of the scalp and widening of the midline parting but with preservation of the frontal hairline. Most will have normal androgen levels but if there is a history of abnormal menses, infertility, hirsutism, unresponsive cystic acne, virilisation or galactorrhoea then a targeted endocrine work-up for hyperandrogenism should be done. Iron deficiency and thyroid disease should be considered as these conditions can contribute to hair thinning or generalised hair loss.

Alopecia areata is a chronic inflammatory non-scarring condition that leads to hair loss ranging from small, well defined patches to complete loss of scalp hair (alopecia totalis). Total loss of all hair (alopecia universalis) can also occur. Men and women are equally affected and, although it can occur at any age, the most common presentation is in children and young adults, 60% of patients experience their first episode of hair loss before 20 years of age. In 80% of affected individuals there is spontaneous regrowth within a year, but further episodes of hair loss are common. Children are most likely to be affected by tinea capitis. It typically presents with a round patch of hair loss associated with scaly erythema of the scalp that may fluoresce under Wood's light depending on the fungal species. Lymphadenopathy is often present.

There are numerous types of scarring (cicatricial) alopecia including central centrifugal cicatricial alopecia, folliculitis decalvans, dissecting cellulitis and acne keloidalis nuchae. However, the two most commonly identified patterns among Caucasians are frontal fibrosing alopecia, a form of follicular lichen planus, and cutaneous lupus erythematosus.

GPs should refer patients in the following circumstances: extensive alopecia; scarring alopecia; diagnostic uncertainty; the patient would like to consider a hair piece or wig; significant associated psychological distress.