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RESIDENT'S FORUM

Frontal Fibrosing Alopecia: An Update on Epidemiology and Treatment☆

FR – Alopecia frontal fibrosante: novedades epidemiológicas y terapéuticas

M. Martínez-Pérez,* M. Churruca-Grijelmo

Servicio de Dermatología, Hospital Severo Ochoa, Madrid, Spain

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Frontal fibrosing alopecia (FFA) is a type of cicatricial alopecia of unknown origin that mainly affects postmenopausal women. The incidence of FFA has continued to increase since it was first described by Kossard in 1994. Despite growing interest in this condition, many questions on etiology and treatment remain unanswered.

We would like to draw attention to the largest series of patients to date, which was recently reported by Vañó et al.,[1] who compiled 355 cases with striking results, such as an increased incidence of early menopause (14% vs 6% in the general population), suggesting that low estrogen levels can play a key role in the etiology of the disease. Also noteworthy is the presence of androgenic alopecia in 40% of patients, which was much greater than in other series,[2] and of hypothyroidism in 15% (4.2% in the general population), which also points to a possible hormonal etiology. Findings such as diffuse reduction in body hair (present in 24%), eyelash loss (14%), and perifollicular papules on the face (14%) are associated with a poorer prognosis and may indicate the need for systemic treatment. However, eyebrow loss as the first manifestation of FFA seems to be associated with milder forms.

The modest findings to date on the treatment of FFA are based on meager and poor quality scientific evidence. In the study by Vañó et al.,[1] the most effective drugs were the 5-alfa-reductase inhibitors finasteride and dutasteride—perhaps because of the high prevalence of female androgenetic alopecia in this series—and intralesional corticosteroids. These data are similar to those reported in a systematic review.[3] Therefore, 5-alfa-reductase inhibitors could prove useful as maintenance therapy: they lead to improvement in 45% of patients and stabilization in 53%.[1] Furthermore, they could be used in

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* Corresponding author.
E-mail address: mrcl_mtnez@yahoo.es (M. Martínez-Pérez).

cases with concomitant androgenic alopecia. Intralesional corticosteroids would be indicated in conditions such as pruritus, erythema, and perifollicular hyperkeratosis, as they lead to partial improvement in 60% of patients and have proven particularly effective in cases of eyebrow involvement, with responses reported in 80% of cases.[3] The efficacy of oral antimalarial drugs is lower (around 30%-40%). Topical calcineurin inhibitors are considered coadjuvant treatment, and the review cited above considers them to be inefficacious when administered alone. Similarly, efficacy has not been demonstrated with minoxidil, topical corticosteroids, hormone replacement therapy, mycophenolate mofetil, tetracyclines, or systemic corticosteroids. Some of the drugs that proved successful in the treatment of lichen planopilaris, of which FFA is considered a clinical variant,[4] may play a role in the treatment of this type of alopecia in the future, especially in refractory cases. Oral ciclosporin led to a response in 60% of patients with lichen planopilaris, although recurrence is frequent once the drug is stopped; therefore, it could be a good candidate for clinical trials involving patients with FFA. Lastly, promising results have been observed in patients with lichen planopilaris treated with rituximab and pioglitazone.

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