Occipital Hair Loss in a 26-Year-Old Man

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A 26-year-old man with no significant medical history presented to our clinic with an area of hair loss on his posterior scalp **(Figure)**. He reported first noticing the hair loss 4 years prior to presentation and denied any changes to the area or development of new lesions since onset. He denied any associated symptoms, including pruritus or tenderness.

A physical examination was notable for a 2.0 × 1.5 cm oval, slightly depressed, partially hairless patch on the occipital scalp. Trichoscopy demonstrated a normal scalp with vellus hairs scattered throughout the patch.

Based on the patient's presentation, what is your diagnosis?

A. Alopecia areata
B. Temporal triangular alopecia
C. Trichotillomania
D. Lichen planopilaris
E. Discoid lupus erythematosus

Figure. Hair loss on the patient's posterior scalp.

Answer: B. Temporal triangular alopecia

The patient was initially diagnosed with alopecia areata based on clinical examination findings. He underwent several courses of treatment with intralesional corticosteroids without improvement. He was subsequently referred to our hair clinic, where a biopsy was performed and demonstrated findings consistent with temporal triangular alopecia (TTA).

Discussion

TTA, also known as congenital triangular alopecia, is a relatively common nonscarring, noninflammatory alopecia. The name congenital triangular alopecia is a misnomer as this condition is generally acquired during the first decade of life, although it can less often be present from birth.[1] Even more rare is adult-onset TTA, which is described in a handful of case reports.[2] TTA affects men and women equally. Most reported cases have been in White patients, although it has also been demonstrated in Asian and Black individuals.[3]

Lesions appear classically as a triangular, lancet-shaped, or ovoid patch of hair loss located on the frontotemporal scalp and remain stable throughout life.[4] Rarely, in up to 2.5% of cases, patients may present with occipital alopecia, as in our case patient.[3] The majority of lesions are unilateral, with an estimated 20% or fewer

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cases described as bilateral.[1,4] Lesions are asymptomatic and there is no associated atrophy, scarring, or discoloration of the skin.[1]

Trichoscopy is characterized by normal follicular openings with vellus hairs surrounded by normal terminal hair area.[5] While biopsy is not always necessary for diagnosis, histology is notable for normal epidermis and dermis, normal number of hair follicles, and small follicular size for the scalp. These findings resemble androgenic alopecia, which is also characterized by miniaturized follicles.[1,4] As such, topical minoxidil has been proposed as a treatment option, although current studies report a lack of therapeutic benefit.[2] The mainstay of treatment for TTA includes surgical excision or hair graft.

Differential diagnosis. Adult-onset triangular alopecia is often confused with alopecia areata, which is another form of noncicatricial alopecia that presents as round or oval patches of hair loss. In contrast to TTA, alopecia areata can occur anywhere on the scalp and may spontaneously enlarge or regrow hair. Trichoscopy can also separate this diagnosis from TTA, as alopecia areata is characterized by broken or tapering hairs or black dots.[5] Also in contrast to TTA, alopecia areata lesions typically respond to corticosteroid therapy.[1]

Trichotillomania is hair loss secondary to self-induced plucking and is often associated with psychologic comorbidities or stressors. Patches have irregular borders and shapes and contain hairs of varying length. Trichoscopy is characterized by incomplete and distorted follicular anatomy.[6]

Lichen planopilaris is an inflammatory, cicatricial alopecia with a female predominance that typically presents with multiple patches of partial hair loss. It is associated with perifollicular erythema, and scarring and lesions are often associated with pruritus and tenderness.[7]

Discoid lupus erythematosus of the scalp is another cicatricial alopecia more common in women. It presents with well-circumscribed round or oval lesions of hair loss with associated scaly plaques, follicular plugging, and pigment changes. Similar to lichen planopilaris, lesions are often symptomatic.[7]

Patient outcome

Our patient opted for surgical excision. Unfortunately, the wound healed poorly with subsequent hypertrophic scar, likely secondary to a suture granuloma. Subsequent scar correction was successful in improving cosmesis.

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