

## Beard involvement in a man with frontal fibrosing alopecia

Sir,

Frontal fibrosing alopecia is a variant of primary lymphocytic cicatricial alopecia, typically observed in postmenopausal women<sup>[1]</sup> with a few cases reported in men.<sup>[2-4]</sup> It is considered a clinical variant of lichen planopilaris producing irregular hair loss from the frontal hairline, preauricular area and eyebrows, with facial papules in the temporal area. Involvement of body hair, mainly affecting axillae, pubis and lower and upper limbs can also occur.<sup>[1,5]</sup> We present a case of frontal fibrosing alopecia in a man with acute hair loss from the beard and limbs.



**Figure 1:** (a) Band of frontoparietal hair recession with partial loss of eyebrows. (b) Marked recession of temporal hairline with complete loss of sideburns. (c) Irregular patches devoid of hairs in lower limbs

A 52-year-old man presented with a 10-year history of progressive recession of the fronto-parietal hairline in a band and marked decrease in hair on the eyebrows [Figure 1a and b]. In addition, the patient complained of sudden, relapsing, asymptomatic, patchy hair loss from the beard [Figure 2] and upper and lower limbs [Figure 1c] which had started 3 years ago and continued to be active. Axillary and pubic hair were normal. Dermoscopic examination of the scalp, beard and lower limbs revealed loss of orifices, peripilar erythema and white concentric scales around the follicular papules [Figure 3c and d]. These dermoscopic findings were more pronounced on the scalp and lower limbs than in the beard and eyebrows, where peri-pilar erythema and perifollicular scales were absent.

Laboratory tests including complete blood count, thyroid screen and antinuclear factor were normal. Histopathological examination of the scalp specimen revealed hair follicles replaced by fibrous tracts and a chronic lymphocytic infiltrate surrounding the follicles. The beard and lower limb biopsies were very similar to the scalp biopsy [Figure 3a and b]. These findings led us to the diagnosis of frontal fibrosing alopecia with beard and body involvement. Various treatments were used viz. topical and oral corticosteroids, hydroxychloroquine and acitretin, which reduced the signs of inflammation but did not slow the course of the alopecia.

Frontal fibrosing alopecia is extremely unusual in men, with only 9 cases reported in the literature.<sup>[2,3,6,7]</sup> It is characterized by a symmetric pattern of progressive recession of the fronto-temporal hairline and a marked decrease or complete loss of eyebrows in 73% of cases.<sup>[1]</sup> Although the “lonely hair” sign can be present in several



**Figure 2:** Non-inflammatory bald patches in the beard

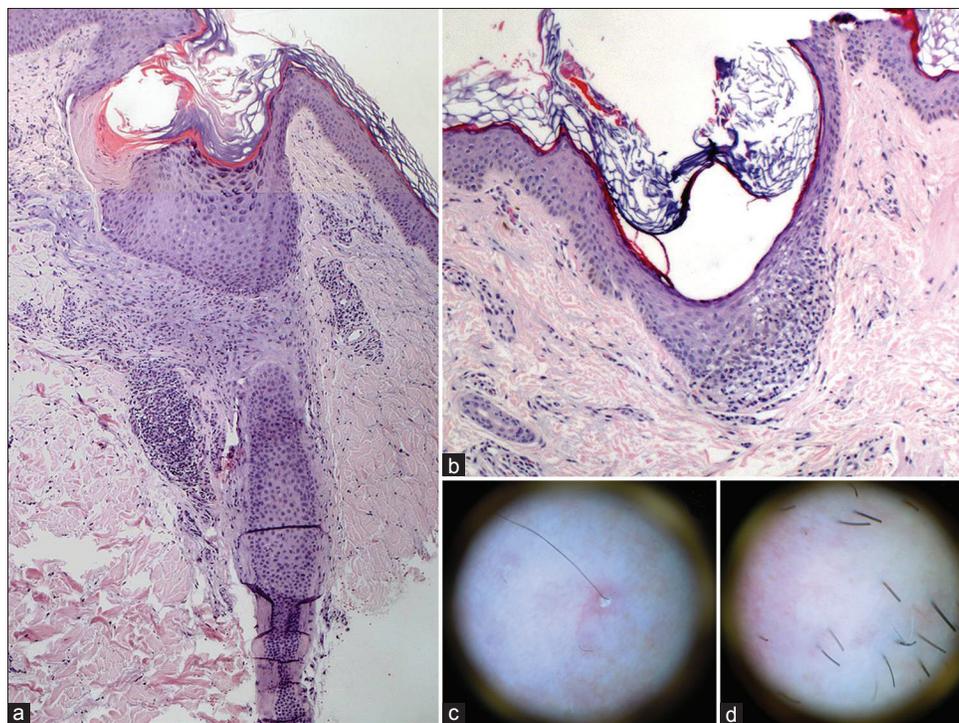
types of cicatricial alopecia, the appearance in the fronto-parietal hairline or sideburns of single hairs that are not grouped in tufts is very specific to frontal fibrosing alopecia.<sup>[8]</sup> Acute loss of body hair has been reported in 25% of cases,<sup>[1]</sup> with no spontaneous regrowth. In men, body and sideburn<sup>[6]</sup> involvement has been described but with few reports of beard involvement.<sup>[4]</sup> As reported by Miteva and Tosti for the limbs,<sup>[5]</sup> frontal fibrosing alopecia of the beard presents as bald patches of sudden onset. Trichoscopy and histopathology are helpful in differentiating this condition from other types of alopecia with body involvement such as alopecia areata and Graham-Little-Piccardi-Lassueur syndrome, with which it may be confused.

In addition to the characteristic fronto-parieto-temporal alopecia of frontal fibrosing alopecia, our patient had large non-inflammatory alopecic plaques on the lower limbs, like those described by Miteva and Tosti, accompanied by similar patches in the beard. Dermoscopic examination revealed lonely hairs with mild asymptomatic follicular papules on the lower limbs. The involvement of the beard was similar to that observed with the eyebrows, with loss of follicular

ostia and lonely hairs observed in the center of alopecic patches, but with no evident peri-follicular erythema or scaling. We found no dermoscopic signs of alopecia areata (yellow dots, cadaverised follicles or dystrophic or exclamation mark hairs).

Interestingly, we observed a slight, partial recovery of the alopecic patches on the body and in the beard. Nevertheless, the successive relapses of alopecic patches in the beard and on the limbs led to progressive scarring alopecia with no regrowth. The inflammatory infiltrate observed in the beard and on the body was less intense when compared with that detected on the scalp. This could explain the absence of inflammatory signs and pruritus, as well as the partial regrowth. Repeated episodes of subclinical inflammation would lead to the development of permanent alopecia in these locations, as occurs on the scalp but at a slower rate.

Our findings in this patient are consistent with the diagnosis of frontal fibrosing alopecia occurring as a generalized process that affected the scalp, eyebrows and other parts of the body. Clinicians should be able to recognize this condition so as to differentiate it from alopecia areata and commence appropriate treatment.



**Figure 3: (a) Histopathology of lower limb shows mild follicular hyperkeratosis and perifollicular lymphocytic infiltration involving infundibulum and isthmus portions of single hair follicle. (H and E,  $\times 40$ ) (b) Histopathology of beard (hematoxylin-eosin; original magnification  $\times 10$ ) shows infundibular lichenoid dermatitis with vacuolar interface changes. (H and E,  $\times 100$ ) (c) Dermoscopy of limb: Loss of orifices and peripilar white concentric scales around the emergence of a follicle. (d) Dermoscopy of beard: Loss of orifices with no other specific findings**

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