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Trichotillomania Mimicking Alopecia Areata in an Adolescent Girl: A Clinicopathologic Case Report

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Abstract

Trichotillomania is a body-focused repetitive behavior classified among obsessive–compulsive and related disorders in the DSM-5. It is characterized by recurrent hair pulling resulting in non-scarring alopecia and may clinically mimic other causes of hair loss, particularly alopecia areata. Early recognition remains challenging because patients often deny hair-pulling behavior and psychiatric stigma may delay appropriate management. We report the case of a 16-year-old girl presenting with frontal scalp alopecia associated with eyebrow and eyelash thinning. Dermoscopic examination revealed broken hairs of varying lengths, V-sign hairs, tulip hairs, and yellow crusts. Histopathologic examination demonstrated preserved pilosebaceous units, increased catagen/telogen follicles, follicular plugging, distorted follicles, and apoptosis of the outer root sheath, supporting the diagnosis of trichotillomania. Despite psychiatric referral, the family declined structured psychiatric management because of sociocultural barriers and reluctance to accept the psychiatric nature of the disease. This case highlights the importance of clinicopathologic correlation in distinguishing trichotillomania from alopecia areata and underscores the psychosocial challenges associated with management in adolescent patients.

Keywords

Trichotillomania; Alopecia areata; Dermoscopy; Histopathology; Adolescent; Hair-pulling disorder.

Introduction

Trichotillomania (TTM), also known as hair-pulling disorder, is a psychiatric condition classified under obsessive–compulsive and related disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). It is characterized by recurrent, irresistible urges to pull out one's own hair, leading to clinically apparent alopecia. The disorder most commonly begins during childhood or adolescence and predominantly affects females. In many cases, trichotillomania is associated with other body-focused repetitive behaviors such as nail biting or skin picking.

Clinically, TTM may mimic several dermatologic conditions, particularly alopecia areata, making diagnosis challenging. Dermoscopy and histopathology are valuable tools that help establish the diagnosis and avoid unnecessary investigations or treatments. Beyond diagnosis, management often requires a multidisciplinary approach involving dermatologists and mental health professionals. However, psychiatric stigma and limited awareness frequently constitute major barriers to care.

We report a case of trichotillomania in a 16-year-old girl initially presenting with patchy alopecia, emphasizing the diagnostic contribution of dermoscopy and histopathology as well as the psychosocial difficulties encountered during management.

Case Presentation

A 16-year-old girl with no significant past medical history presented to our dermatology department with progressive frontal scalp alopecia evolving over one year. The patient initially denied compulsive hair pulling but admitted to nail-biting behavior, particularly during stressful situations.

Clinical examination revealed irregular alopecic plaques involving the frontal hairline with preservation of follicular openings. Marked thinning of the eyebrows and eyelashes was also noted. No erythema, atrophy, or scarring was observed.

Dermoscopy demonstrated several characteristic findings including broken hairs of varying lengths, V-shaped hairs, tulip hairs, dystrophic short hairs, and yellowish crusts and scales, strongly suggesting trichotillomania.

A 4-mm punch biopsy was performed from the affected scalp. Histopathologic examination showed a moderately acanthotic and irregularly papillomatous epidermis with focal orthokeratotic hyperkeratosis. Follicular ostia were dilated and filled with pigmented keratotic plugs, frequently lacking visible hair shafts. The dermis showed no fibrosis and only mild superficial perivascular lymphocytic infiltrates. Pilosebaceous units were preserved, with an increased proportion of catagen and telogen follicles. Several follicles appeared distorted or incompletely keratinized, and follicular infundibula frequently contained pigmented plugs. Extensive apoptosis of the outer root sheath was also observed.

Clinicopathologic correlation confirmed the diagnosis of trichotillomania.

The patient and her family received counseling regarding the diagnosis, and referral to child psychiatry was recommended. However, the family expressed difficulty accepting the psychiatric nature of the condition and declined pharmacologic therapy and structured psychiatric follow-up. Their reluctance

appeared related to limited awareness of trichotillomania and sociocultural stigma surrounding psychiatric disorders in pediatric patients.

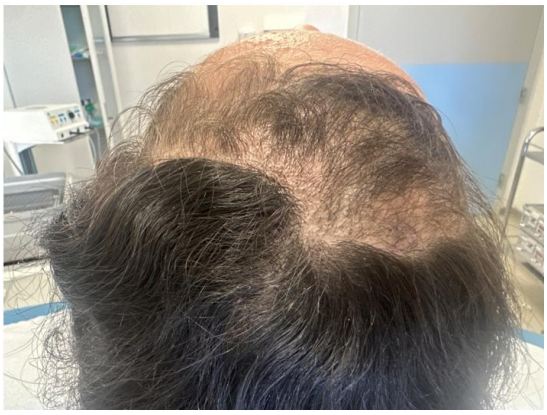

Figure 1: Alopecia in the frontal scalp.

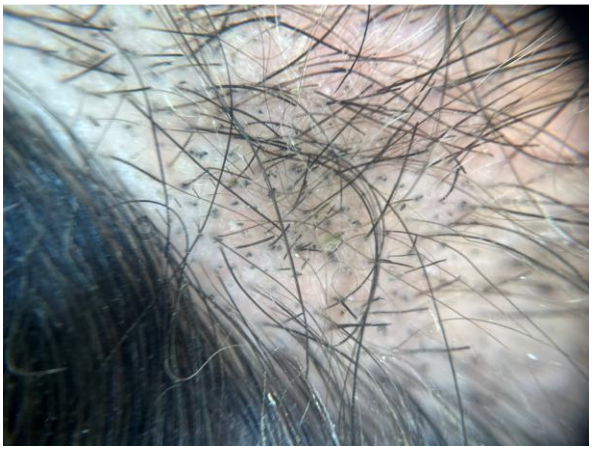

Figure 2: Dermoscopy showed broken hair of different length, V-shaped hairs and tulip hairs.

Figure 3: UV dermoscopy of the frontal scalp revealing broken hairs of varying lengths, black dots, dystrophic short hairsf, and follicular keratotic plugs with whitish-yellow scaling, consistent with trichotillomania.

Discussion

Trichotillomania is estimated to affect approximately 1%–3% of adolescents, with a marked female predominance. The condition typically presents as irregularly shaped patches of non-scarring alopecia with hairs of different lengths. Involvement of eyelashes and eyebrows, as observed in our patient, strongly supports the diagnosis.

Dermoscopy represents a useful noninvasive diagnostic tool in trichotillomania. Common findings include broken hairs of varying lengths, black dots, coiled hairs, tulip hairs, V-sign hairs, and yellow crusts. These features help distinguish TTM from alopecia areata, in which exclamation mark hairs and yellow dots are more characteristic.

Histopathology remains particularly valuable in diagnostically challenging cases. Characteristic histologic findings include trichomalacia, distorted hair shafts, increased catagen and telogen follicles, pigment casts, follicular plugging, and minimal inflammatory infiltrate. Absence of fibrosis helps differentiate TTM from cicatricial alopecias. Our case exhibited several of these classic histopathologic features, including follicular distortion, catagen/telogen predominance, pigmented follicular plugs, and apoptosis of the outer root sheath.

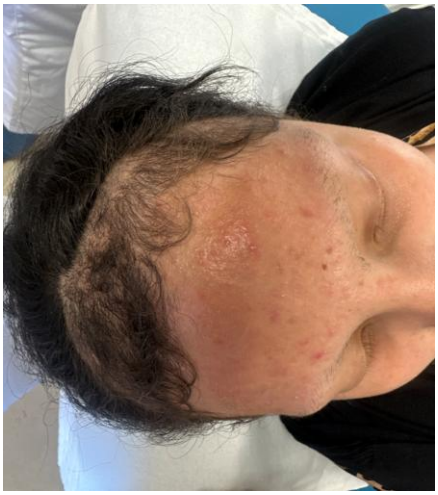

Figure 4: Clinical presentation showing irregular non-scarring alopecic plaques involving the frontal scalp and hairline, associated with diffuse thinning of the eyebrows and eyelashes, suggestive of trichotillomania.

Management of trichotillomania remains difficult and often requires a multidisciplinary approach. Behavioral therapies, especially habit reversal training, are considered first-line treatment. Pharmacologic therapies such as selective serotonin reuptake inhibitors and N-acetylcysteine may be useful in selected or refractory cases. Nevertheless, psychiatric stigma and denial frequently impair adherence to treatment. In our patient, parental reluctance to pursue psychiatric care represented a major obstacle despite clear clinicopathologic confirmation of the diagnosis. [1-2].

This case highlights the importance of early recognition of trichotillomania and emphasizes the role of psychosocial and cultural factors in treatment acceptance.

Conclusion

Trichotillomania should be considered in adolescents presenting with irregular patchy alopecia, particularly when associated with eyebrow or eyelash involvement. Dermoscopy and histopathology provide important diagnostic clues and help distinguish this condition from alopecia areata and other causes of hair loss. Early multidisciplinary management is essential to reduce psychosocial consequences and improve outcomes. However, sociocultural stigma surrounding psychiatric disorders may significantly limit treatment acceptance and remains an important challenge in patient care.

Declarations

Ethics approval and consent to participate

Informed consent was obtained from the patient's legal guardians for publication of this case report and accompanying images.

Conflict of interest

The authors declare no conflicts of interest.

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Author contributions

All authors contributed to the conception, drafting, revision, and final approval of the manuscript.

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