**Disorders of the scalp**

Hilda O’Shea outlines some common scalp disorders and their management

**SCALP CONDITIONS** are often seen in general practice.

Alopecia areata presents as a solitary bald patch usually on the scalp but it can occur in any hair-bearing area including eyebrows, eyelashes, beard and body areas and can be anything from 1cm in diameter to 6cm and can occur at any age. They usually heal in six to nine months but can recur in a small percentage of cases. It may occur in more than one member of the family. Alopecia areata is not contagious and is not caused by food.

The cause is unknown but some consider it as an autoimmune disease. Lymphocytes around the hair follicles release cytokines that reject the hair. It occurs more frequently in atopics, thyroid disease and pernicious anaemia. Best prognosis is if it is central, doesn’t reach the hair line and if it is the first episode. Five percent of individuals with alopecia areata go on to lose all the hair on their scalp – this is known as alopecia totalis and can be very long-lasting. Alopecia universalis occurs in 1% of patients and with this condition all body hair is lost. Treatment is re assurance as to a positive outcome in the majority of cases. Topical steroids have been tried but with no convincing effect.

Diffuse baldness in women is another condition that can be very distressing. These women feel they are going to go completely bald as they are losing clumps when they wash or brush their hair. Causes are often linked to severe infection in the previous few months. Iron deficiency anaemia, hypothyroidism or drugs are some of the rarer causes and can be checked by FBC ESR ferritin and thyroid profile and rectified with appropriate medication. Hair loss experienced after pregnancy is something similar. Again, this is usually a temporary hair loss – sometimes called telogen effluvium and the hair will recover in six to nine months.

Tinea of scalp and scalp ringworm occur mainly in children. I have seen a few cases in African children living in institutionalised accommodation. It presents as a postular soggy swelling on the scalp, 6cm-7cm in diameter. Hair bulbs and swab should be sent to microbiology to show positive culture for tinea. Treatment in children is confined to Grisofulvin orally as Lamisal is not licensed for this age group. Grisofulvin has to be ordered in specially from the health board and is very expensive. I also apply Lamisal topically. It can take eight to 10 weeks to clear.

Scalp psoriasis can be diffuse or in patches. The scale accumulates in thick patches which are often itchy and this leads to secondary infection. Sites are above the ears, crown and hair line. It may occur in isolation or with other forms of psoriasis and it tends to be a chronic problem lasting several years. The complete scalp or just sections may be affected. Patients develop a thick silvery white scale on patches of red skin that may extend beyond the hairline. In severe cases there may be temporary hair loss.

Treatment is with Cocois Scalp Solution or Tam Pomade applied for three nights in a row and washed off in the morning. Then repeat the following week for two nights and reduce to once weekly until scalp is cleared. This can last for two to three months so Cocois has to be prescribed in sufficient quantities. It’s difficult to wash out and Fairy Liquid can be used to good effect and then one’s preferred shampoo applied afterwards. Coal Tar shampoos are not sufficient to remove the scale but can be used to maintain scalp afterwards. Dovonex lotion helps to keep the scale from accumulating and can be used between applications of Cocos. If the scalp is sore and red following scale removal Bettamouse helps. It’s easier to apply than other steroid creams on the scalp.

Psoriasis amiantacea is characterised by thick yellow-white scales coating the skin and adhering to the scalp hairs as they exit from the skin. They appear as a series of overlapping flakes on the skin which may or may not be scaly and red. It usually affects part of the scalp but occasionally involves the whole scalp. It is sometimes found in young girls extending into the scalp from areas of cracked skin behind the ears. Often the cause is not obvious but can appear in association with psoriasis or seborrhoeic dermatitis. There is often temporary hair loss which can occasionally become permanent if infection and scarring occur. Treatment is the same as for scalp psoriasis.

Seborrhoeic dermatitis occurs on the scalp, eyebrows, nasolabial folds and front of chest. The scale tends to be more yellowish than silvery and has a greasy appearance. It can be variably severe, persistent and occurs at any time after puberty. Often difficult to differentiate from psoriasis and may be referred to as sebopsoriasis. It is not a contagious condition but may be related to reduced general health. Scalp psoriasis responds well to shampoos such as Nizoral or Capasal left on for a few minutes before rinsing off.

Folliculitis keloidalis also known as acne cheloidalis, is a condition I’m beginning to see more frequently. It can occur in any individual but commonly occurs in adult African males. It appears as small round bumps close to the hair-bearing area at the back of the neck. These are ingrown hairs which irritate the wall of the hair follicle and result in inflammation. Eventually, the bumps become small hairless scars along the hairline. Treatment of the condition is not successful, but oral tetracycline or antibiotics are helpful for secondary infections.

Molluscum contagiosum is another increasingly common condition occurring in the nape of neck in young adult men and I wonder if it is being passed on in the local barber’s shop. Treatment is with cryotherapy.

Head lice. When someone presents with an itchy scalp it’s the first condition to be considered. Look with a magnifying glass and all will be revealed. I use Priderm lotion or Lyclear left on for 12 hours and repeat in one week.

Hilda O’Shea is a GP in Cork City