

Very Late Onset "Trichotillomania": A Case Report

Çok Geç Başlangıçlı "Trikotilomani": Bir Olgu Sunumu

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Abstract

Trichotillomania is a chronic psychiatric disorder that repetitive hair pulling which leads to marked hair loss, negative effects on all areas of the person's functioning. Although trichotillomania has been known for many years, it has attracted less attention than other psychiatric disorders. Therefore, the information about its epidemiology, etiology, clinical feature and therapeutic approaches are limited. Trichotillomania usually begins in early childhood or adolescence. It is more common in women than men. Cases are frequently referred to the first dermatology outpatient clinics due to marked hair loss. Trichotillomania is one of the common issues of psychiatry and dermatology. In patients with trichotillomania, comorbid psychiatric disorders often accompany the clinical picture. The most common psychiatric comorbidities are mood disorders and anxiety disorders. In this study, we report a male patient who was treated with a diagnosis of very late onset trichotillomania with comorbid depression. The fact that trichotillomania started at an advanced age is a feature that makes our case interesting.

Keywords

Trichotillomania, very late onset, comorbidity

Anahtar Kelimeler

Trikotilomani, çok geç başlangıç, eştanı

Received/Geliş Tarihi : 11.01.2015

Accepted/Kabul Tarihi : 16.10.2015

doi:10.4274/meandros.2054

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Öz

Trikotilomani, yineleyen saç yolmalar sonucu belirgin saç kaybına yol açan, kişinin işlevselliğinin tüm alanlarını olumsuz etkileyen süregen seyirli bir ruhsal bozukluktur. Trikotilomani uzun yıllardır bilinmesine rağmen diğer ruhsal bozukluklardan daha az ilgi çekmiştir. Bu nedenle epidemiyolojisi, etiyolojisi, klinik görünümü ve tedavi yaklaşımları ile ilgili bilgiler sınırlıdır. Trikotilomani genellikle erken çocukluk ya da ergenlik döneminde başlar. Kadınlarda erkeklere göre daha sık görülmektedir. Belirgin saç kaybı nedeni ile olgular ilk kez dermatoloji polikliniklerine başvururlar. Trikotilomani psikiyatri ile dermatolojinin ortak konularından biridir. Trikotilomanili olgularda eş tanıli psikiyatrik bozukluklar da sıklıkla klinik tabloya eşlik eder. En yaygın görülen psikiyatrik eş tanılar duygudurum bozuklukları, anksiyete bozukluklarıdır. Bu çalışmada eştanılı depresyonu da olan çok geç başlangıçlı trikotilomani tanısı ile tedavisi düzenlenen bir erkek olgu sunulmuştur. Trikotilomaninin ileri yaşta başlamış olması olgumuzu ilginç kılan bir özelliktir.

Introduction

Trichotillomania is a psychiatric disorder that repetitive hair pulling behavior leading to marked hair loss, severe, progressive and difficult to treat. As Hautmann and others (1) reported, even though trichotillomania has been known since the 12th century, it was described for the first time in the late 19th century by a French dermatologist Francois Hallopeau. Trichotillomania lexically means uncontrolled hair pulling in ancient Greek (2). Even though it has been known for a long time, epidemiology, etiology and treatment approaches of trichotillomania are still not known exactly today. In other words, it took less attraction in comparison with other psychiatric disorders although it has been known for many years. As a result of trichotillomania, complete or partial alopecia occurs in the scalp in most cases. According to basic clinical data in recent terms trichotillomania is seen more common than it was believed to occur in the past. This disorder starting in infancy and adolescence period and typically appearing in critical developmental periods may reoccur in other parts of the life as a result of unwanted and distressing situations (2,3). Although trichotillomania can be seen in every age, starting age is average 12-13 (4,5). It generally starts before the age of 20, while it rarely starts after 20. It is mostly seen between the ages of 11 and 15 (2,6). It is reported that in the early type which starts before 6 the rate of male and female equals to each other and this type gives a good respond to the treatment with a better clinical course. It is also reported that late start trichotillomania which is seen after 13 is more seen on girls tend to becoming chronic and reveal comorbidity and resistance to the treatment (7,8). The studies related to *etiology of trichotillomania* and treatment have been increased in the last 20 years. Especially, new factors such as relaxation training, making patients raise awareness on the habit, self monitoring, and training on reversing the habit as treatment approach (2). Even though the reasons taking role in etiology of trichotillomania are not definitely known, it is thought that biological, psychological and social factors are effective. The findings which refer to that hair pulling behaviour is more seen in the families of the cases indicates the importance of the genetic predisposition on which

many various genes take role (9-11). In this study a very late start trichotillomania patient, not defined in literature before and accompanied by depressive symptoms is presented under literature knowledge.

Case Report

The case is 72 years old, male, married, retired, primary school graduate and has five children. He was born in a village of Rize. He still lives with his family in the same village. He applied to our outpatient clinic at the recommendation of his family and also voluntarily as he had the habit of pulling hair and other hairs on his body.

History: This behaviour of the patient who started to pull his hairs on his body as far as his hand reach about 4 years ago emerged mostly when he had a trouble. The patient said that in those times he felt itching in hair and hair roots and overwhelmingly wanted to pull his hair. He also added that he enjoyed the sound which he heard while pulling his hairs because this relaxed him and during that he did not feel any pain. The patient who threw his hairs around randomly after pulling them said the feeling of itching was lost and he felt relaxed afterwards. He also reported that he sometimes regretted pulling hairs but he could not stop doing this. He repeated this 4 or 5 times a day and almost everywhere. Sometimes he suddenly felt this while he was performing prayer, he could not beat this and started to pull his hairs and discontinued his prayer. His 41 year old son died 18 months earlier. After he lost his child, he had complaints such as adductive, forgetfulness, sleeplessness, not enjoying the life, but there was increase in the behaviour of the patient who did not have any treatment during that time.

Developmental History

The patient who led all his life in the village where he was born was born by normal delivery. He had no problem during the growth and development periods. He had umbilical hernia operation 15 years earlier and cataract operation 6 years earlier. He had had a regular benign prostatic hyperplasia treatment for 3 years. There was no neurologic disease story in the family. Any change was not defined in the sleep and appetite habits of the patient who was outgoing and had a lot of friends before the illness. On the other hand, after he got the illness, he did not go out much and did not see his friends.

Physical Examination and Laboratory Findings

In the physical examination of the patient, apparent hair loss was observed especially on the arms and legs of the patient. It was also seen that there were scar tissues and colour changes on the skin as a result of hair pulling. On the other hand, there were different lengths and areas not affected by hair pulling and seen normal in the alopecia part as a classical finding of trichotillomania. Also there was apparent localized hair loss in the frontotemporal part of the patient (Picture from 1 to 3). Hair pulling was undulatory from a central part. The patient was wearing a hat and had a beard to hide the hair loss. The patient was directed to dermatology polyclinic for his skin lesions and his necessary topical dermatological treatment was started. His electroencephalography (EEG) included normal findings. In the magnetic resonance imaging, slight explicitness was determined in the hemispheric cortical sulcus. In the other parts his age compatible changes were reported. Any pathological findings were not obtained from the patient who was examined in terms of dementia. Hemogram value, thyroid and parathyroid hormones, ferritin, vitamin B12, folic acid and syphilis tests were done and any pathological findings were not seen. The Mini-Mental State Examination (MMSE) was evaluated as 28 points.

Mental State Examination

Apparent hair loss in the body of the male patient, looking in his age, having compatible clothing to socio-demographic level, respectful, having eye contact, and with partly reduced self care was remarkable. During the interview, he gave brief and clear short answers to the questions. The tone of his voice was normal. Especially, he had a rising anxiety when hair pulling was mentioned. His sensitivity was depressed and his sensation was troublesome. His consciousness was open, oriented and cooperative. No pathological finding was detected in the perception. Memory capacity, intelligence level, the ability to assess reality and judgement were normal. His connotations were in regular thinking content and his disease, his case and his treatment, and the problems which he had with his family were related to insignificance and guilt feelings. His self esteem was reduced.

Findings

Following the psychiatric examination, the patient was diagnosed with major depressive disorder and

trichotillomania and treated with fluoxetine 20 mg/day (12).

Hamilton Depression Rating Scale (HDRS) was 18 points and Hamilton Anxiety Assessment Scale (HAAS) was 12 points. The patient and his family were informed about the disease and the treatment. After the eighth week of the treatment, apparent improvement in the symptoms of depression anxiety of the patient was observed. Also HDRS and HAAS points decreased. Especially raising the awareness for hair pulling was emphasized during patient interviews. The patient said that he felt discomfort because of hair pulling. In the next phase the treatment was carried on with cognitive behavioural therapy (CBT) with the patient whose awareness was raised. The patient was asked to record his feelings and thoughts while pulling hairs, but he could not comply with it. On the other hand, it was observed that the patient who communicated in a difficulty when he first applied to the clinic expressed himself better in later interviews. He gained new skills to control his behaviours. Apparent improvement in hair pulling behaviour of the patient was determined in the fourteenth week of the treatment even though hair pulling seldom iterated from time to time with stress factors. His treatment is still going on. The patient was informed before the study and his written and verbal informed consent was obtained.

Discussion

Trichotillomania may cause serious worsening on the life quality by affecting the relationships between people, avoiding society and social activities, losing self control, feeling low respect with disappointment and affecting productivity negatively. Hair was pulled mostly from the vertex and then from the temporoparietal, occipital and frontal regions on the scalp (1,5). In the presented case hair pulling from vertex and temporal region complies with the literature information. Some positive or negative reinforcers about hair pulling take role in the continuation and the irritation of the action (5,6). In this case satisfaction and pleasure can be seen as positive reinforcers, while an unwanted affection or avoiding and recession from a situation can be seen negative reinforcers. It is known that patients tend to hide hair pulled parts (1,2,13). The fact that the patient came to the interview proves this. A

view which supports that trichotillomania is seen in both genders and the rate of females' increases in advancing ages has a command. On the other hand, that trichotillomania is seen in males less than in females can be males' hiding hair pulling, decreasing hair pulling, and their preference to have their hair cut to struggle against hair pulling, or explaining this with male type alopecia. In addition another reason is that male patients apply to clinics less than female patients or they go to a clinic very much later (2-5). Our patient's being male and applying to the clinic 4 years after his disease started supports these results. It is stated that feelings mostly expressed before the action are anxiety, tension, boredom and guilt. When feelings before and after the action are compared, it is seen that the biggest change is in the feelings of guilt, boredom, comfort, sadness and anger (14,15).

Tension which occurred before hair pulling and comfort which was felt after the action in DSM-IV-TR criteria were determined in our case. However, tension before the action and comfort and pleasure after the action taking place among previous diagnostic criteria in newly published DSM-5 diagnose and classification system were removed and instead iterating reducing hair pulling and stopping it criterion was placed (16). Also, it was reported that there was stressful events and trauma stories which started the illness in our case (2,17). It is remarkable in the case that increase in the complaints of the patient was observed after his son suddenly died. Even though the knowledge related to an efficient treatment is quite limited, prevalence and possible effects on life quality of trichotillomania were defined. In the studies for adult sample group with trichotillomania Axis I disorder existence during and before diagnosis was reported 82% (18). Most frequently seen togetherness is mood and anxiety disorders. Swedo and Leonard (19) (1992) determined the unipolar depression rate as 39% for a mixed sample group formed with children, teenagers, and adults with trichotillomania. In the presented case comorbid depression complies with those results. As in other psychiatric disorders, that trichotillomania is together with other psychiatric disorders makes diagnosis in the patients difficult, and also negatively affects the treatment and the prognosis of the disease. Questioning the disorders in routine psychiatric examinations and semi structured interviews will be beneficial for early diagnosis. Although there is

not enough evidence, firstly with selective serotonin reuptake inhibitors (SSRIs), clomipramine and other antidepressants there are CBT as effective therapies (20-28). Also, fluoxetine was preferred for the treatment of our patient. As a result of controlled studies, CBT, mainly Habit Reversal Training (HRT), arranged to raise the awareness on hair pulling are more effective in automatic pulling, whereas the strategies based on cognitive and adoption are more effective in focused pulling (29). For our case firstly awareness for hair pulling was provided and then the treatment was carried out with cognitive behaviourist techniques. Hiding hair pulling behaviours or limited or late application to the treatment due to embarrassment restrains wide controlled studies to be done. In our study similarly it is obvious that our case who had a late standard trichotillomania applied to the treatment very late and there was functionality.

In conclusion, it should not be forgotten that although trichotillomania is a psychiatric disorder accepted to start in early ages, it is also possible for it to be seen in old ages. To understand trichotillomania better, wide scale epidemiologic studies, arrangement of objective criterion of functionality disorder, searching pain tolerance in detail, and controlled studies which can compare psychological (supporting) and pharmacological treatments with CBT peculiar to young and old patients are required.

Ethics

Informed Consent: The patient was signed an informed consent form. He was photographed with plaque zones for comparison before and after the treatment.

Peer-review: External and internal peer-reviewed.

Authorship Contributions

Surgical and Medical Practices: M.A., Ç.H., N.D., Concept: M.A., Ç.H., D.Y., Design: Ç.H., N.D., Data Collection or Processing: M.A., D.Y., Analysis or Interpretation: Ç.H., N.D., Literature Search: M.A., D.Y., Writing: M.A., Ç.H., N.D.

Conflict of Interest: No conflict of interest was declared by all authors .

Financial Disclosure: The authors declared that this study received no financial support.

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