

Central centrifugal cicatricial alopecia: A call for additional literature in the pediatric population

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Sir,

Central centrifugal cicatricial alopecia (CCCA), formerly known as *follicular degeneration syndrome* or *hot comb alopecia*, is a lymphocytic scarring alopecia seen more commonly in females of African descent [1]. However, emerging literature suggests a prevalence in adolescent Black and Asian populations [2,3].

The variability in the presentation of CCCA requires a high index of suspicion in the pediatric population. Classically, patients in the adult population present with hair loss to the vertex of the scalp, which spreads laterally and forward. However, other presentations vary from hair breakage to the vertex of the scalp with the later addition of papules and pustules to a patchy alopecia involving the vertex and the parietal and occipital scalp [1,2]. Clinical mimickers may, therefore, include tinea capitis, traction alopecia, androgenetic areata, and alopecia areata [4]. This letter aims to highlight the importance of entertaining it as a differential diagnosis in this population.

Scarring alopecia is rare in the pediatric population, likely due to a low index of suspicion and late presentation [5]. There is a paucity of literature on the demographics, clinical presentation, prevalence, and treatment outcomes for scarring alopecia in the pediatric population. This deficit extends to medical education, as these authors have observed that entire book chapters geared toward primary physician education of scarring alopecia omit the differential diagnosis of CCCA [6].

The common modalities employed to diagnose CCCA include dermoscopy and histopathology, with the finding of peripilar, grayish-white halos surrounding the emergence of 1–2 hair follicles in the former being highly sensitive and specific for the diagnosis of CCCA [4]. Because both CCCA and tinea capitis may present with pruritus, scaling, and hair breakage, a potassium hydroxide (KOH) preparation or fungal culture may be warranted to exclude the latter [4]. Timely diagnostic intervention is critical as the hair follicles slowly burn out [3,5,7]. In a study by Imhof et al., the average time from symptom onset to the diagnosis of scarring alopecia in a pediatric population was 17.1 months, and the concurrent psychiatric co-morbidities included anxiety (22.2%) and depression (22.2%) [7]. This finding reinforces the importance of having a low diagnostic threshold to decrease overall morbidity. Psychologic burden and quality of life are reportedly more severely impaired in patients with scarring alopecia [7]. This is likely a result of the poorer responses to therapy and the associated symptomatology, such as pain, burning, and pruritus [4,7]. Successful treatment of CCCA generally requires combination and systemic therapies, such as topical and intralesional corticosteroids, topical minoxidil, oral tetracyclines, hydroxychloroquine, and oral retinoids [7]. However, further data is needed to outline the most efficacious treatment modalities for the pediatric population.

In conclusion, a deficit of literature surrounding pediatric scarring alopecia, particularly CCCA, exists in online medical databases. More studies need to be conducted to determine the epidemiology, clinical

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presentations, treatment outcomes, and comorbidities in the pediatric population.

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

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