TRICHOSCOPIC COMPARISON BETWEEN TELOGEN EFFLUVIUM AND ANDROGENIC ALOPECIA

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ABSTRACT

Background: Alopecia, is a major condition that affects both sexes and people of all ages. Hair loss is the most common reason for women to consult a dermatologist, apparently because of cosmetic reasons. Androgenetic alopecia and Telogen Effluvium have greater rates of occurrence and sensitive responsiveness to timely treatments. Trichoscopy helps in diagnosis, determining the biopsy location, and providing prognostic information. Dermatologists can examine the scalp with a handheld dermoscope (x10 magnification). Vascular patterns, follicular and perifollicular features, and hair shaft features are among the dermoscopy results.

Objective: To compare the prevalence of trichoscopic characteristics of the scalp in Androgenic Alopecia and Telogen Effluvium on the basis of follicular patterns, interfollicular patterns, and hair features.

Methods: The study is a cross-sectional study conducted at the Azadi teaching hospital, in the Department of Dermatology, Venereology from December 2021 to May 2022, on a total sample size of 80 patients diagnosed clinically to estimate the prevalence of trichoscopic characteristic differences in each androgenetic alopecia and telogen effluvium using the Dermlite DL4 dermoscope, which allows for 10-fold magnification of the examining area .

Results: Among the eighty cases, 40 cases had Androgenetic alopecia and 40 had telogen effluvium. In telogen effluvium, heterogeneity in hair shaft diameter in frontotemporal areas (15%), vellus hair (32.5%), Up growing hair (65%), 1-2 hair per follicle (17.5%), 3-multiple hair per follicle (82.5%), Yellow spots (5%), peripilar sign (20%), and are some of the most common results. in patients with Androgenetic alopecia, the distinguishing observation is that hair shaft diameter variation is common in the fronto-temporal and occipital regions (100% percent). Increase in number of miniaturized hair more than 20% is (97.5%), vellus hair (70%), upgrowing hair (27%), 1-2 hair per follicle (60%), 3- multiple hair per follicle (40%), yellow spots (57.5%) and Peripilar sign (35%) are all follicular characteristics found with androgenetic alopecia.

Conclusion: Trichoscopy is a good tool for differentiation between the two diffused alopecia androgenic alopecia and telogen effluvium. On Trichoscopy, in androgenetic alopecia the fronto-temporal zones had the most variation in hair shaft diameter. The peripilar sign, yellow spots, and empty hair follicles were the most common follicular features. Miniaturized hair was the most common hair shaft pattern seen androgenetic alopecia. On Trichoscopy, telogen effluvium is described as disease of exclusion needs further research. It's vital to distinguish this disorder from androgenetic alopecia, which has hair shaft thickness variations in the fronto-temporal areas but none in the occipital.

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Keywords: Alopecia, Androgenetic alopecia, Hair loss, Telogen effluvium, Trichoscopy.

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Alopecia can reflect the loss of hair follicles, loss of hair shafts, or loss of both.[1] Although alopecia may be present since birth, it is more often acquired. Androgenetic alopecia and telogen effluvium being the most common forms of alopecia.[2]

Scalp dermoscopy, also known as trichoscopy, is a noninvasive method for evaluating individuals with hair loss that provides for a magnified view of the hair and scalp skin.[3] A hand held dermoscope (10 magnification) or a videodermoscope (up to 1,000 magnification) can be used. This procedure is useful for diagnosis, treatment and follow-up monitoring.[4]

Telogen Effluvium (TE)

TE can start at any age, with a sudden rise in hair loss and the frontal hair density remaining constant. Factors typically connected with the illness include surgery, fever, delivery, iron shortage, stress, chronic diseases, and dietary changes.[5] The most usual time period between the trigger factor exposure and the development of the illness is two to three months, with acute variants lasting four to six months. The inciting event is thought to prompt early entry into the telogen phase, causing the usual asynchrony in regular hair loss to undergo a synchronic shedding period. Vegetarians are at risk for TE, thus dietary limits, particularly protein and iron restrictions, should be observed. Hyperpolymenorrhagia could be the cause of iron deficiency if the menstrual cycle is evaluated. Thyroid issues have been linked to weight gain.[6] Weight loss or food restriction that occurs suddenly, such as following bariatric surgery, might cause TE. Antidepressants, contraceptives, and polyvitamins, for example, must be monitored while starting or stopping treatment or changing dosage.[7]

Chronic forms of TE, especially when the trigger factors are consistent or several, can have shedding durations of more than six months.[8] A recent study suggested that chronic types of TE may be caused by a shortening of the anagen phase of the follicle, with an average development duration of 18 months (instead of four to six years).[9] TSH and ferritin measurements are used in basic laboratory tests to rule out two of the most prevalent causes of TE: iron insufficiency (which is rarely enough to induce alterations in the blood count) and hypothyroidism. The best test to reflect a bone marrow aspirate is ferritin testing, which should be more than 60ng/dl. The saturation index and total iron-binding capacity appear to be less essential.[10]

Androgenetic Alopecia (AGA)

It is an androgen-dependent, heritable disorder that follows a predictable pattern. It's thought that androgen-stimulated hair follicle miniaturization affects genetically predisposed hair follicles, resulting in the gradual replacement of big, pigmented terminal hairs with nearly invisible and depigmented vellus hairs in affected locations. As a result, visible scalp hair density decreases with time.[11] Individual susceptibility to hair loss and its severity is also determined by local factors. A highly ordered intrinsic susceptibility of hair follicles to androgen gives a specific pattern of hair loss.[12]

Occipital hair is resistant to androgens, even when it is transplanted into the vertex.[13] However, vertex hair continues to miniaturize when transplanted on the forearm. Itami and Inui proposed that the

second-messenger system determines whether androgen causes hair growth in beard and axillary area and at the same time miniaturizes terminal hair on the scalp.[14]

Female androgenetic alopecia (FAGA) is distinguished by its more diffuse thinning of the crown area with an intact frontal hairline, which generally starts in women in their late 20s and affects over 30% of women aged 70 years or more.[15] Male androgenetic alopecia (MAGA) is best described by its typical bitemporal thinning of the hair and balding vertex.

The dermatoscopic forms more commonly seen or observed solely, particular types of alopecia were the following features: empty follicles, ,hair diameter diversity, and peripilar sign in androgenetic alopecia.[16] while dermatoscopy in patients with telogen effluvium revealed thin, smooth, and visibly open follicles on the scalp. Hair follicle appeared to be blocked by keratotic plugs, hair regrowth in certain patients. This hair growth was homogenous, indicating an early illness remission (upright "vellus" hairs).

PATIENTS AND METHODS:

Study design

The present study design is a cross-sectional study which included 80 patients with two variants of hair disorders; 40 patients with telogen effluvium either chronic (duration more than 6 months) or acute (duration 1-6 months). and 40 patients with androgenic alopecia. The samples were collected from the Out-Patient Clinic of Dermatology and Venereology Department, Azadi teaching hospital. The study was approved by the Research Ethics Committee of Medical college of Duhok University. All participants signed an informed consent before participation in the study.

Patient population:

The mean age was 37 (20-60) years in patients with AGA, 29 (18-50) years in patients with Telogen effluvium. The differences were statistically not significant. With p-value= 0.0002.

Inclusion criteria

Our study included patient's being over[18] years of age of both sexes and agreeing to participate in our study.

Exclusion criteria

Patients with any scalp dermatological problems, any type of hair loss other than Telogen effluvium and Androgenic Alopecia were excluded from the study. Such as tinea capitis, scalp seborrheic dermatitis, psoriasis, and DLE, as well as other disorders.

Trichoscopy:

A trichoscope (dermoscop) was used to assess all samples of six areas of the scalp, (bilateral fronto-temporal, bilateral parieto-temporal, vertical and occipital). Trichoscopy was performed using the Dermlite DL4 dermoscope, which allows for 10-fold magnification of the scalp. Images of the scalp were captured at a 10-fold magnification, which allows for a high-quality enlargement of 1 cm2 of scalp region.

STATISTICAL ANALYSIS:

The general information of the patients with hair loss was presented in mean (SD), median (IQR), or number (%). The prevalence of past medical and drug history was determined in number (%). The prevalence of dermoscopy findings was determined in number (%). The

comparisons of general and medical information between patients with Androgenic alopecia and telogen Effluvium were examined in an independent t-test and Pearson chi-squared tests. Comparisons of dermoscopy findings between patients with Androgenic alopecia and patients with Telogen Effluvium was examined in Pearson chi-squared test. The significant level of difference was determined in a p-value of less than 0.05. The statistical calculations were performed in JMP Pro 14.3.0.

RESULTS:

Among 80 patients participated in this study were 40 cases of AGA (50%) and 40 cases of TE (31.25% acute, 18.75% chronic).

Socio-demographic characteristics:

Mean age(SD) for AGA was (37.6 years and SD (10.73) while for the TE was (29.5 years and SD (7.18).

According to the anthropometric measurements, mean BMI for AGA was 26.17 and for TE was 24.92. as in table 1.

Sex distribution: Out of the 80 patients that were included in the study, the percentage of male patients having AGA was 47.5% and the percentage of female patients having AGA was 52.5%. The percentage of male patients having TE was 27.5 and the percentage of female patients having the same was 72.5%. Most of the male patients presenting with hair loss was diagnosed with AGA more than TE. While females were more diagnosed with TE.

There was no significant difference in between the two conditions AGA, TE in marital status, educational status, job, social status.

Table 1: Comparisons of Socio-demographic characteristics between patients with Androgenic alopecia and Telogen Effluvium

General information	Hair loss types no (%)		p-value
	Androgenic alopecia (n=40)	telogen Effluvium (n=40)	
Age mean (SD)	37.63 (10.73)	29.56 (7.18)	0.0002a
Study groups			
20-30	12 (30.00	18 (45.00	
30-40	13 (32.50	18 (45.00	
40-50	9 (22.50	4 (10.00	0.0192b
50-60	6 (15.00	0 (0.00	
BMI mean (SD)	26.17 (3.49)	24.92 (2.93)	0.0885a
Underweight	0 (0.00	1 (2.50	
Normal weight	18 (45.00	18 (45.00	0.6984b
Overweight	16 (40.00	17 (42.50	
Obese	6 (15.00	4 (10.00	
Gender			
Male	19 (47.50	11 (27.50	0.0647b
Female	21 (52.50	29 (72.50	
Marital status			
Divorced	1 (2.50	0 (0.00	0.4292b
Married	25 (62.50	22 (55.00	
Single	14 (35.00	18 (45.00	

General information	Hair loss types no (%) Androgenic alopecia (n=40)	telogen Effluvium (n=40)	p-value
Education			
Illiterate	8 (20.00	7 (17.50	
Primary school	3 (7.50	3 (7.50	0.5302b
Secondary school	10 (25.00	16 (40.00	
University	19 (47.50	14 (35.00	
Job			
Employed	16 (40.00	7 (17.95	
Housewife	10 (25.00	18 (46.15	0.0691b
Student	5 (12.50	8 (20.51	
Worker	9 (22.50	6 (15.38	
Social status			
Poor	6 (15.00	10 (25.00	0.4558b
Average	18 (45.00	18 (45.00	
Good	16 (40.00	12 (30.00	

a an independent t-test and b Pearson chi-squared test were performed for statistical analysis.
The red bold numbers show the significant differences.

According to the onset of the hair fall AGA showed more gradual onset (95%) than sudden onset (5%); however, TE had more sudden onset (32.5%) of the disease than gradual (67%) as in fig.1 and in table2.

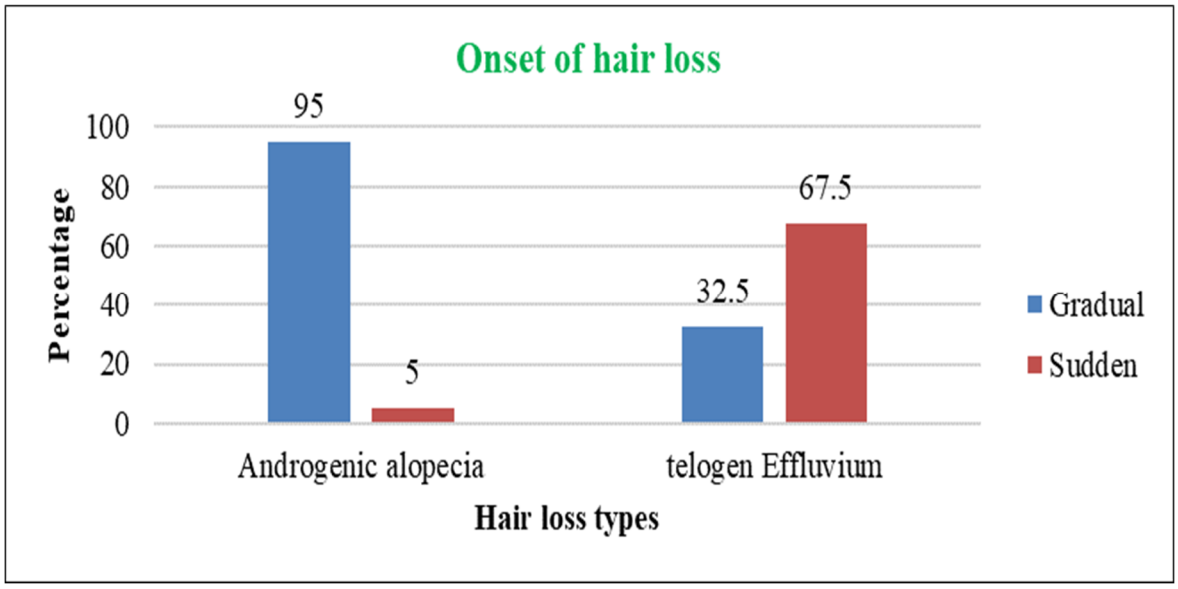

Figure 1: the onset of the hair fall

According to family history of hair loss was more obvious among AGA patients than TE.

65% to 22.5%. A positive family history was more obvious in AGA than in TE, 56% to 22.5% as shown in table 2.

Most of the participant 80% did not have any symptoms of hyperandrogenism. Irregular menses was present only in 5% of AGA while it was not present in any cases of TE. Multiple hyperadrogenic symptoms

together such as hirsutism, acne, obesity in addition to the irregular menses where found in about 10% of female androgenic alopecia. However, each symptom

individually could been present in TE as well. As shown in table 2.

Almost all cases of TE hair loss were diffuse all over the scalp (92.5%) and 7.5% were central in distribution. In contrast with AGA patients 47.5% central, 22.55 Centro-temporal, 25% temporal and only 5% general(diffuse). As shown in figure 2 and table 2.

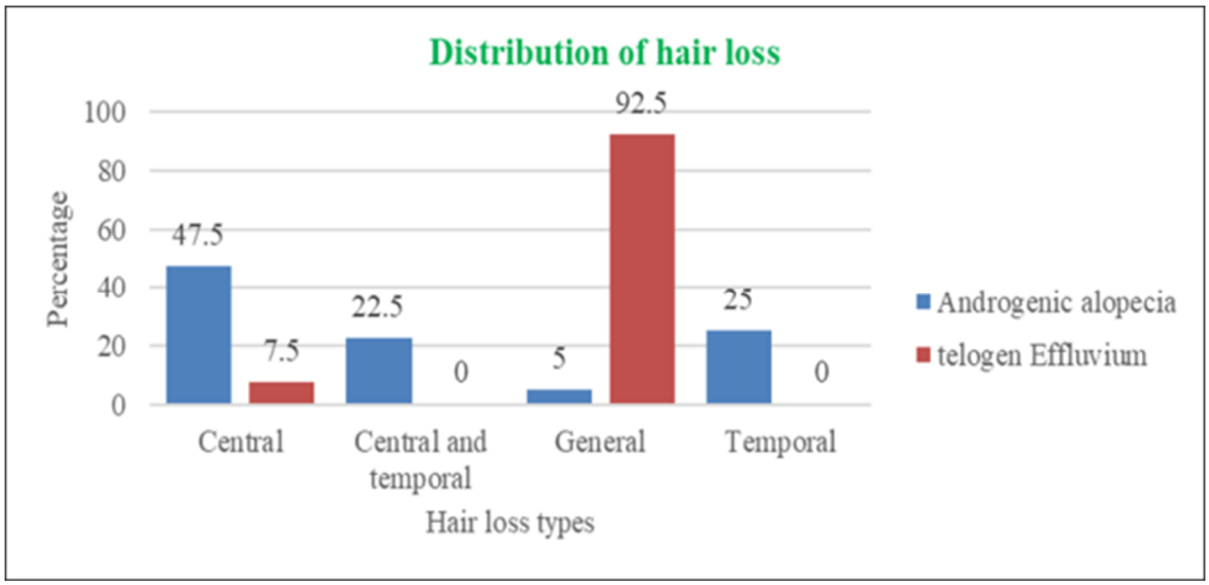

Figure 2: distribution hair loss (main site of hair loss)

There was no significant differentiation in local symptoms associated with the hair fall (like itching or pain), history of treatment received, pat medical, surgery and diet. As shown in table 2.

Table 2: Comparisons of medical and diagnostic information between patients with Androgenic alopecia and patients with Telogen Effluvium

Information	Hair loss types no (%)		p-value
	Androgenic Alopecia (n=40)	Telogen Effluvium (n=40)	
Onset of hair loss			
Gradual	38 (95.00	13 (32.50	<0.0001
Sudden	2 (5.00	27 (67.50	
Symptoms			
Asymptomatic	28 (70.00	30 (75.00	0.4199
Itching	10 (25.00	6 (15.00	
Pain	2 (5.00	4 (10.00	
Treatment			
No treatment	20 (50.00	24 (60.00	0.4281
Single treatment	12 (30.00	12 (30.00	
Multiple treatment	8 (20.00	4 (10.00	
History			
No medical history	37 (92.50	35 (87.50	0.7449
Diet	2 (5.00	3 (7.50	
Surgery	1 (2.50	2 (5.00	
Family history of hair loss			0.0001
No	14 (35.00	31 (77.50	

Information	Hair loss types no (%)		p-value
	Androgenic Alopecia (n=40)	Telogen Effluvium (n=40)	
Yes	26 (65.00	9 (22.50	
Hyperandrogenism			
No hyperandrogenism			
Acne	31 (77.50	33 (82.50	
Hirsutism	1 (2.50	2 (5.00	
Hirsutism, irregular Menses, obesity	1 (2.50	2 (5.00	
Hirsutism, irregular Menses, obesity, and acne	2 (5.00	0 (0.00	0.3657
Hirsutism, obesity and acne	2 (5.00	0 (0.00	
Irregular Menses	0 (0.00	1 (2.50	
Obesity	2 (5.00	0 (0.00	
Obesity and acne	1 (2.50	1 (2.50	
Distribution of hair loss	0 (0.00	1 (2.50	
Central			
Central and temporal	19 (47.50	3 (7.50	
General	9 (22.50	0 (0.00	<0.0001
Temporal	2 (5.00	37 (92.50	
Past medical history	10 (25.00	0 (0.00	
No medical history			
DM	37 (92.50	39 (97.50	0.3583
HTN	2 (5.00	0 (0.00	
Past drug history	1 (2.50	1 (2.50	
No past drug history			
Antihypertensive	36 (90.00	39 (97.50	
OHA	1 (2.50	0 (0.00	0.4838
Others	2 (5.00	1 (2.50	
	1 (2.50	0 (0.00	

Pearson chi-squared test were performed for statistical analysis.
The red bold numbers show the significant differences.

Tricoscopic findings (table 3):

Prevalence of Presence of hair shaft diversity

All of AGA 100% had hair shaft diversity in specially central or temporal area. Only 6% of TE had this diversity. (p-value = <0.0001) considered the most significant differentiation between the two conditions.

Prevalence of Up growing hair:

Up growing hairs was found in 40% of AGA in mild-moderate cases and new cases. Also in 65% of TE in acute cases. (p-value = 0.0008). presence of up growing hair is sign of the good prognosis of the disease which is much more in TE especially acute ones.

Prevalence of Hair per follicular unite:

60% of AGA cases had 1-2 hair per follicular unite in severe cases and 40% of them had 3-multiple hair per follicllar uite. While most cases of TE 82.5% had a normal number of hair per follicular unite (3-multiple). (p-vale< 0.0001). significant difference is that presence of normal hair shafts per follicular unite is more likely sigh of TE rather than AGA.

Prevalence of Yellow Dots

On Trichoscopic Examination of six areas of the scalp, (bilateral fronto-temporal,

bilateral parieto-temporal, vertical and occipital) yellow dots were present (≥ 1 field or; < 4 fields or) in 57.5% patients of AGA and 5%of TE. The above data suggests that yellow dots are present in increasing frequency in AGA (57.5%) than in TE (5%). With p-value < 0.0001.

Prevalence of Peripilar sign (brown dots): Brown discoloration representing perifollicular inflammation was present in 35% of AGA, and in 20% of TE. The difference is not significant with P value = 0.1330.

There were no significant trichoscopic differentiation in between TE and AGA in about, scalp surface (greasy, hyperkeratotic, dry, perifollicular plug and cast).

Table 3: Comparisons of trichoscopic findings between patients with Androgenic alopecia and patients with telogen Effluvium

Trichoscopy findings	Hair loss types no (%)		p-value
	Androgenic alopecia (n=40)	telogen Effluvium (n=40)	
Presence of hair shaft diversity			
No	0 (0.00	34 (85.00	<0.0001
Yes	40 (100	6 (15.00	
Up growing hair			
No	29 (72.50	14 (35.00	0.0008
Yes	11 (27.50	26 (65.00	
Hair per follicular unite			
1-2 hair	24 (60.00	7 (17.50	<0.0001
Three hairs per follicular unite	16 (40.00	33 (82.50	
Yellow dotes (empty follicle, keratin only)			
No	17 (42.50	38 (95.00	<0.0001
Yes	23 (57.50	2 (5.00	
Brown color surrounding hair follicle (perifollicular inflammation, peripilar sign)			0.1330
No	26 (65.00	32 (80.00	
Yes	14 (35.00	8 (20.00	
Black dots			
No	35 (87.50	39 (97.50	0.0895
Yes	5 (12.50	1 (2.50	
Greasy interfollicular sapce			
No	16 (40.00	10 (25.00	0.1521
Yes	24 (60.00	30 (75.00	
Hyperkeratotic interfollicular sapce			
No	38 (95.00	38 (95.00	1.0000
Yes	2 (5.00	2 (5.00	
Dry interfollicular sapce			1.0000
No	37 (92.50	37 (92.50	
Yes	3 (7.50	3 (7.50	
Perifollicular Hyperkeratotic plugs			0.6442
No	37 (92.50	38 (95.00	
Yes	3 (7.50	2 (5.00	
Perifollicular cast			0.1521
No	40 (100	38 (95.00	
Yes	0 (0.00	2 (5.00	

Pearson chi-squared test was performed for statistical analysis.

DISCUSSION

1-Hair shaft characteristics:

a-Variation in hair shaft thickness in AGA has been identified by trichoscopy as having a higher percentage of diversity between frontotemporal and occipital.[17]

In this study presence of hair diameter diversity was found in all cases of AGA and was much higher than in other types of hair loss. More than 20% of hair diameter diversity is thought to be a necessary criterion for diagnosing AGA and FPHL. As According to de Lacharrière et al., the predominant and most accurate clinical criterion connected to follicle shrinking was hair diameter diversity.[17] Hence, in our study hair diameter diversity was considered as sole diagnostic criteria for AGA, using a photographic scale for bedside use.

The presence of hair of various calibers is typical of AGA and represents the disease's gradual hair miniaturization. As Tosti et al. proposed that a diversity of more than 20% is diagnostic of AGA in a study. This characteristic, which may not always be evident to the human eye, can be better visualized via trichoscopy. Because >20 percent hair diameter diversity is also seen in a tiny percentage of normal persons, its occurrence in the general population should be investigated further. These healthy individuals should be biopsied if possible to seek for an underlying androgenetic process. If not, such patients should be followed for the development of female pattern hair loss over a long period of time.[18]

b-Up growing hairs:

In our study the up growing hairs was more obvious in TE cases mostly in acute onset, although its not considered as significant finding to differentiate between AGA and TE. It is a representation of a good prognosis and sign of growing of the hair and a healthy scalp. Also it is a sign of good response to the treatment as in alopecia areata. As was found in another study by Jain N et la.[19]

2-Follicular characteristics:

a-Follicular unite:

Number of hair per one follicular unit tends to be normal and multiple in acute cases of TE and become less (1-2) hair per one follicle in chronic cases, as a previous study by Rakowska et la revealed that hairs are typically found in bands of a few hair roots growing from a single follicular unite. Trichoscopy at a 20-fold magnification was used to count the quantity of hairs in pilosebaceous units. The proportions of single-hair, double-hair, and triple-hair units were estimated. The temporal areas had the largest number of single-hair pilosebaceous units in both healthy individuals and chronic telogen effluvium. However, AGA cases were more likely to have less hair per follicle unites in response to androgen shrinkage especially in severe cases.[20]

b-Yellow dots:

Yellow dots were more seen in AGA case, which represented degenerating follicular keratinocytes. However small amount could be seen in a normal scalp. As according to Rakowska et la, this dots distinguishes these structures from yellow dots found in other disorders, which are primarily composed of keratotic material. The existence of intact sebaceous glands adjacent to miniaturized hair follicles is indicated by these yellow dots.[21]

c-Peripilar sign (brown dots):

Peripilar signs (brown dots) representing perifollicular inflammation were mostly present in AGA cases 32% than TE 26%, but considered with less significance for the diagnosis as it was confirmed by previous study that Perifollicular browning of the skin is another significant trichoscopy observation. The presence of perifollicular lymphocytic infiltrates in early androgenic alopecia is reflected by this characteristic, which some writers refer to as "hyperpigmentation" or "peripilar sign." in AGA, however, the percentage of hair follicles with this abnormality is massively higher in the frontal area than in the occiput in FAGA. A ratio of hair follicles with perifollicular discoloration and frontal area to occiput more than 3:1 is strongly diagnostic of AGA.[21]

3-scalp surface and vascularity has not been found to be significant in this study. The scalp surface and vascularity seem to be normal in both TE and AGA. However, most cases had a greasy scalp that represents the skin type of the majority of the region's population. According to Rakowska et al confirmed a nonsignificant of dermoscopy in AGA. Also, in another research, he found these characteristic findings significant more in scaring types of alopecia such as DLE, Folliculitis decalvans, and Dissecting cellulitis.[22]

CONCLUSION

The two most common diffuse hair loss conditions Androgenetic Alopecia and Telogen Effluvium can be differentiated by trichoscop. Hair shaft thickness diversity, increased number of minturized hairs, increased yellow dots and a large number of follicular units with only one arising hair shaft are the main trichoscopic features of androgenetic alopecia. The absence of these features is the most telling trichoscopic sign of Telogen Effluvium.

CONFLICT OF INTEREST

There is no conflict of interest.

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پوخته

بەراوردکرنا لێنێرینا پرچێ دناڤبەرا وەریانا پرچێ یا کربی و پنیبونا نێرینە

ئارمانج: هەلسەنگاندنا رادێ بەلاڤەبوونا تایبەتییێن پرچا سەر د پنیبوونا نێرینە و وەریانا پرچێ یا کربی ل سەر بنیاتێ شێوازێن چلکدانێ و شێواز دناڤبەرا گوریاتیێ و نیشانێن پرچێ.

ڕێکێن کارکرنێ: ئەڤ ڤەکولینە ڤەکولینەکا کەرتی یە و ل سەر نموونەکێ ژ (80) نەخۆشان ل نەخۆشخانا ئازادی یا فێرکرنێ ل بەشێ نەخۆشییێن پیستی و زاوزێ هاتەکرن ژ هەیڤا کانونا ئێکێ 2021 هەتا هەیڤا گولانێ 2022 بو هەلسەنگاندنا لایێن جیاوازیا تایبەتییێن لێنێرینێ دناڤبەرا پنیبوونا نێرینە و وەریانا پرچێ یا کربی.

ئەنجام: ژ (80) حالەتان، چار حالەتان گازندە ژ پنیبوونا نێرینە دکرن و چل ژ وان وەریانا پرچێ یا کربی لنك هەبوو، دگەل جیاوازیەك د چێوەیێ رهکا موی ل دەڤەرێن پێشیێ و دەرکەفتی (15 ٪)، پرچا زختك (32,5 ٪) وەرارا پرچێ (65 ٪) ، 1 2 موی بو هەر رهکەکێ، (17,5 ٪)، پنیێن زەر (5 ٪)، نیشانا رەخ و دور (20 ٪) و 3 مویێن هەمەجور بو هەر رهکەکێ (85 ٪)، کو ژ هەمی ئەنجامان پتر بەلاڤەیە. لنك نەخۆشییێن گازندێ ژ پنیبوونا نێرینە دکەن، تێبینیا بەرچاڤ ئەوە کو گوهورینا قەدێ موی تشتەکێ بەلاڤەیە ل دەڤەرێن پێشیێ و دەرکەفتی و هەستیکێ قەزالی (100 ٪) دگەل زێدەبوونا ژمارا مویێن هویرکۆك پتر ژ (20 ٪) کو (97,5 ٪) ، پرچا زختك (7 ٪) و نیشانا رەخ و دور (35 ٪)، وەرارا پرچێ (27 ٪)، 1 2 موی بو هەر رهکەکێ (60 ٪) و 3 مویێن هەمەجۆر بو هەر رهکەکێ (40 ٪)، پنیێت زەر (57 ٪) هەمی تایبەتییێن گوریاتییێنە و دگەل پنیبوونا نێرینە هاتنە دیتن.

دەرئەنجام: د لێنێرینا پرچێ، دەڤەرێن پێشیێ دەمکی پتر د جیاوازبوون ل چێوەیێ ستوینا موی، و نیشانێن رەخ و دور، و پنیێن زەر، و رهکێن پرچێ یێن ڤالا نیشانێن گوریاتیەکا پتر بەلاڤە بوون د پنیبوونا نێرینە. پرچا بچویکری شێوازێن پتر بەلاڤە یا قەدێن پرچێ. دلێنێرینا پرچێ، وەریانا پرچێ یا کربی دهێە وەسفکرن کو نەخۆشیەکا دویرئێخستنێ یە، یا گرنگ ئەوە جیاوازیەك هەبیت دناڤبەرا تێکدانێ و دناڤبەار پنیبوونا نێرینە کو جیاوازی هەنە د ستویراتیا قەدێ موی ل دەڤەرێن پێشیێ و دەمکی لێ تشتەك د قەزالیدا نیە.

الخلاصة

مقارنة تَنْظيرُ الشَّعْو بين تساقط الشعر الكربي والثعلبة الذكورية

الخلفية والأهداف: الثعلبة، أو تساقط الشعر، هي حالة رئيسية تصيب كلا الجنسين من جميع الأعمار ويعتبر تساقط الشعر السبب الأكثر شيوعًا لاستشارة النساء لطبيب الأمراض الجلدية، وذلك لأسباب تجميلية على ما يبدو ويمكن وصف تساقط الشعر بأنه إما ندبي أو غير كاتبي، اعتمادًا على المدة التي يستمر فيها التلف الذي يصيب بصيلات الشعر.

الصلع الوراثي والتساقط الكربي لهما معدلات حدوث أكبر واستجابة اسرع للعلاجات في الوقت المناسب و يساعد تنظير المشعرات في التشخيص وتحديد مكان الخزعة وتوفير المعلومات التنبؤية.

الهدف: تقيم مدى انتشار خصائص فروة الرأس في الثعلبة الذكورية وتساقط الشعر الكربي على أساس الأنماط الحويصلية والأنماط بين الجريبات وعلامات الشعر.

طرق العمل: تعتبر هذه الدراسة، دراسة مقطعية أجريت على حجم عينة إجمالي من 80 مريضًا في مستشفى آزادي التعليمي، في قسم الأمراض الجلدية والتناسلية ، من ديسمبر 2021 إلى مايو 2022 . لتقييم اوجه اختلاف الخصائص التنظيريه بين الثعلبة الذكورية و تساقط الشعر الكربي.

النتائج: من بين 80 حالة، اربعون حالة كانوا يعانون من الثعلبه الذكورية و اربعون منهم كانت لديهم تساقط الشعر الكربي مع تباين في قطر جذع الشعرة في المناطق الأمامية والصدغية (15٪)، الشعر الزغبي (32.5٪)، نمو الشعر (65٪)، 1-2 شعرة لكل بصيلة (17.5٪)، بقع صفراء (5٪) ، علامة محيطية (20٪) و3 شعرات متعددة لكل بصيلة (85%) وهي من أكثر النتائج شيوعًا في المرضى الذين يعانون من الثعلبة الذكورية ، فإن الملاحظة المميزة هي أن تغير قطر جذع الشعرة أمر شائع في المناطق الأمامية والصدغية والقذالية (100%) مع زيادة في عدد الشعيرات المنمنمة بأكثر من 20٪ هي (97.5٪) ، الشعر الزغبي (70٪), كانت العلامة المحيطية (35%) ، نمو الشعر (27٪) ، 1-2 شعرة لكل بصيلة (60٪) , 3- شعرات متعددة لكل بصيلة (40%), البقع الصفراء (57%) كلها خصائص جرابية وجدت مع الثعلبة الذكورية.

الاستنتاجات: في تنظير الشعر، كانت المناطق الأمامية-الزمانية هي الأكثر تباينًا في قطر عمود الشعرة، حيث كانت العلامات المحيطية، والبقع الصفراء ، وبصيلات الشعر الفارغة هي السمات الجريبية الأكثر شيوعًا في الثعلبة الذكورية. كان الشعر المصغر هو أكثر أنماط جذوع الشعر شيوعًا في تنظير الشعر، يوصف تساقط الشعر الكربي بأنه مرض الاستبعاد. من المهم التمييز بين هذا الاضطراب وبين الثعلبة الذكورية الذي له اختلافات في سماكة جذع الشعرة في المناطق الأمامية والزمنية ولكن لا شيء في القذالي.