Research letter

Frontal fibrosing alopecia in men: A multicenter study of 39 patients

To the Editor: Frontal fibrosing alopecia (FFA) is a primary lymphocytic scarring alopecia with a higher prevalence among postmenopausal women. Short case series and clinical reports have reported FFA affecting men. This multicenter, observational, and retrospective study aimed to collect a large series of male patients with FFA from different Spanish hospitals to describe the epidemiology and family history, autoimmune comorbidities and urologic diseases, clinical presentation, association with hormonal imbalance, trichoscopy findings, and use of sunscreens and leave-on facial moisturizers. The patients in this study provided written informed consent to publish their case details. Results are shown in Table I.

The mean age at diagnosis, race distribution, and lack of family background of FFA were similar to those reported in previous series.[1-3] In contrast, the mean time between the onset of the clinical presentation of FFA and the diagnosis was higher in our series, a fact that could be explained because FFA was an incidental diagnosis and not the main concern for consultation. In relation to this, 38.5% of our patients did not demand any treatment, which could explain why the age of diagnosis was so delayed.

The rate of beard alopecia in our study was 74.4%, and a higher number of patients showed sideburn alopecia (Fig 1). We would like to emphasize that FFA should be included in the differential diagnosis of eyebrow and beard alopecia in men, along with other forms of alopecia, such as alopecia areata or lichen planopilaris. FFA should be considered a systemic condition that does not exclusively affect the scalp, but also the hair of the face and the rest of the body.

In our study, 3 patients with prostate adenocarcinoma had undergone treatment with antiandrogenic drugs (bicalutamide and goserelin or triptorelin) before the onset of FFA. These drugs decrease the circulating levels of testosterone in the blood and lead to the development of a secondary hypogonadism. This led us to think that an imbalance in sex hormone levels might play a key role in the development of FFA in men, similar to what happens in postmenopausal women.[4] However, this contrasts with the fact that in some cases, 5-α reductase inhibitors are used as a treatment for FFA. Prospective studies should be conducted to assess causality between these drugs and FFA. Further study is needed to better characterize hormonal levels and any potential associations and to investigate any causation between hormonal imbalances and the development of FFA.

Facial sunscreens or facial moisturizers with any sunscreen filter were reported to be frequently applied by 56.4% of our patients, in accordance to other series. This is one of the main hypotheses postulated for the etiopathogenesis of FFA, but actually there is no evidence to support the recommendation to avoid the application of sunscreens.[5]

To our knowledge, we report on the largest multicentric series of FFA affecting males, including demographic, clinical, and trichoscopic features. Beard and eyebrow alopecia were present in a great number of patients. We highlight the cases in association with prostate diseases such as prostate adenocarcinoma, benign prostate hyperplasia, and those in which there is a sex hormone profile alteration. Trichoscopic characteristics in male FFA are reported, including changes in the scalp and hair shafts.

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Table I. Differences between our case series and previous case series of FFA in men reported in the literature

	Current study	Ormaechea-Pérez et al[2]	Tolkachjov et al[1]	Alegre-Sánchez et al[3]
No. of patients	39	12	7	12
Mean age, years (range)	69 (46-89)	75 (63-85)	54 (33-71)	47
Mean duration of FFA	7.1 years	2.5 years	22 months	5.6 years
Race	Caucasian 97.4% South-American 2.6%	Caucasian 100%	Caucasian 100%	Caucasian 100%
Family history	1 (2.6%)	0 (0%)	Not reported	Not reported
MAGA	30 (76.9%)	10 (83%)	1 (14%)	8 (67%)
Hypothyroidism	2 (5.1%)	0 (0%)	0 (0%)	0 (0%)
Benign prostate hyperplasia	13 (33.3%)	0 (0%)	Not reported	Not reported
Prostate adenocarcinoma	6 (15.4%)	1 (8%)	1 (14%)	1 (8%)
Facial papules	13 (33.3%)	6 (50%)	0 (0%)	4 (33%)
Frontal veins depression	5 (12.8%)	Not reported	Not reported	Not reported
Rosacea	12 (30.8%)	Not reported	Not reported	Not reported
Sideburns alopecia	35 (89.7%)	Not reported	4 (57%)	Not reported
Beard alopecia	29 (74.4%)	1 (8%)	1 (14%)	6 (50%)
Eyebrow alopecia	37 (94.9%)	10 (83%)	3 (43%)	7 (58%)
Eyelash alopecia	1 (2.6%)	Not reported	0 (0%)	1 (8%)
Body hair alopecia	23 (59%)	10 (83%)	2 (29%)	5 (42%)
Occipital involvement	9 (23%)	1 (8%)	2 (29%)	4 (33%)
Perifollicular erythema	24 (61.5%)	8 (66%)	Not reported	Not reported
Perifollicular hyperkeratosis	29 (74.4%)	8 (66%)	Not reported	Not reported
Loss follicular openings	37 (94.9%)	12 (100%)	Not reported	Not reported
Biopsy	10 (25.6%)	5 (42%)	7 (100%)	12 (100%)
Facial sunscreen/moisturizers use	22 (56.4%)	0 (0%)	Not reported	Not reported
Hormonal treatments	4 (10.3%)	0 (0%)	0 (0%)	1 (8%)
Hormone levels	Among 19 (48.7%) patients, 11 (28.2%) had normal levels, 4 (10.3%) had low or undetectable testosterone levels, 2 (5.1%) had high PSA levels, and 3 (7.7%) had high SHBG levels	Not reported	2 (29%) had low free testosterone levels	Not reported

FFA, Frontal fibrosing alopecia; *MAGA*, male androgenetic alopecia; *PSA*, prostate-specific antigen; *SHBG*, sex hormone binding globulin.

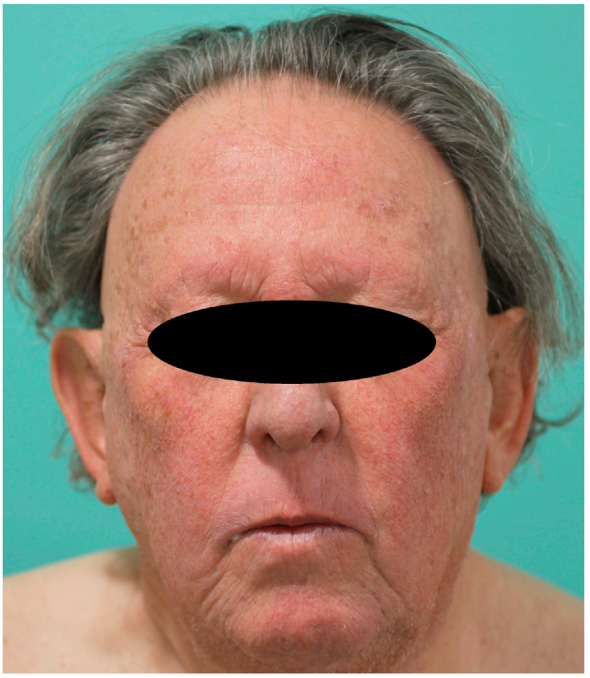

Fig 1. Frontal fibrosing alopecia in a man showing frontal and temporal hairline recession; complete sideburn, eyebrow, and beard alopecia; facial papules; and rosacea.

Reprints not available from the authors.

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Conflicts of interest

None disclosed.

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