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Skin of Color Update 2024 Bioderma Congress Reports

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Diversity in dermatology clinical trials

Speakers: Valerie M. Harvey, Andrew F. Alexis, and Cheryl Burgess

Diversity in dermatology clinical trials: Where do we stand? What can we do?

Valerie M. Harvey, MD, MPH, FAAD

Dr. Valerie Harvey highlighted the ongoing lack of progress in improving diversity within dermatology trials, which continues to exacerbate health disparities. Despite efforts, only 30% of psoriasis trials have demonstrated adequate diversity. Dr. Harvey emphasized the urgent need for more diverse cohorts in clinical studies, which would help rebuild trust and improve access to life-saving treatments for underrepresented populations. Increased diversity will also provide valuable insights for the safe and effective use of medical products across different demographic groups.

In response to this issue, the FDA has drafted a "Diversity Action Plan," which will impact all clinical studies enrolling participants 180 days after the final guidance is published, expected by June 2025.

Dr. Harvey also pointed to the need for improved definitions and instruments to describe skin of color (SOC) in clinical dermatology. She stressed the importance of removing biased SOC descriptors and eliminating gender classification in trials. Additionally, there is a need for better validated tools to measure SOC, moving beyond the outdated Fitzpatrick Skin Type classification. The new tools should be feasible in terms of time, cost, and reliability.

Emerging tools in development include the Eumelanin Human Skin Color scale, the Individual Typology Angle, and the Monk Skin Tone scale, which aim to more accurately assess and represent SOC in clinical trials.

Recent notable & newsworthy drug approvals: What's new in the medical dermatology armamentarium for patients with Skin Of Color

Andrew F. Alexis, MD, MPH, FAAD

Dr. Andrew Alexis recently discussed significant drug approvals that expand the medical dermatology armamentarium for patients with skin of color. Among the notable approvals is the PDE4-inhibitor: **Roflumilast 0.3% cream**, approved for the treatment of psoriasis in patients aged 6 years and older. Additionally, **Roflumilast 0.15% cream** has been approved for mild-to-moderate atopic dermatitis (AD) in patients aged 6 years and older with very rapid relief of pruritus (even after only one application). **Roflumilast 0.3% foam** for the treatment of seborrheic dermatitis in patients aged 9 years and older has also been approved. The foam formulation offers a convenient option for managing seborrheic dermatitis, particularly in areas like the scalp, which can be challenging to treat, especially in patients with SOC. These formulations act as phosphodiesterase-4 (PDE4) inhibitors, which increase cyclic AMP (cAMP) levels, suppressing pro-inflammatory mediators and enhancing the production of anti-inflammatory mediators. Another noteworthy approval is Tapinarof 1% cream, indicated for the treatment of plaque psoriasis in adults. Tapinarof is also in development for atopic dermatitis, showing promise as an innovative treatment for both conditions. Tapinarof is a small molecule topical therapeutic classified as an aryl hydrocarbon receptor (AhR) modulating agent (TAMA). Its proposed mechanism of action involves activation of the AhR pathway, which helps to regulate skin immune responses and reduce inflammation. By modulating this receptor, Tapinarof promotes the production of anti-inflammatory proteins while suppressing pro-inflammatory cytokines, aiding in the restoration of skin barrier function. This mechanism is believed to contribute to its effectiveness in treating inflammatory skin conditions such as plaque psoriasis and, in the future, atopic dermatitis. In the Tapinarof Extension Trial, patients who entered the study with a Physician Global Assessment (PGA) score of 0 (clear skin) experienced a remittive effect lasting an average of 115 days. One of the most commonly reported side effects was folliculitis, occurring in 22.7% of patients. However, it was noted that these were more often hyperkeratotic follicular papules, rather than the typical presentation of folliculitis.

Recent advancements in biologics for dermatological conditions include several notable approvals:

1. Bimekizumab, the first dual inhibitor targeting both IL-17A and IL-17F. Clinical trials have shown that Bimekizumab achieves greater skin clearance compared to Secukinumab, another IL-17A inhibitor. However, it has been associated with an increased risk of oral candidiasis (mild to moderate), a known side effect of IL-17 inhibition. Notably, the incidence of inflammatory bowel disease (IBD) in patients treated with Bimekizumab was not higher than with other IL-17 inhibitors, offering reassurance regarding its safety profile in this regard. (Also being investigated for hidradenitis suppurativa)
2. Secukinumab has recently been approved for the treatment of hidradenitis suppurativa (HS). Administered every two weeks, secukinumab has shown clinical efficacy in rapidly improving the signs and symptoms of HS, irrespective of prior biologic exposure. In clinical trials, it demonstrated a favorable safety profile with a sustained response lasting up to 52 weeks of treatment.
3. Tralokinumab has been approved in an autoinjector form for the treatment of moderate to severe atopic dermatitis (AD), providing a convenient option for patients requiring long-term therapy.
4. Lebrikizumab received FDA approval on September 13, 2024, for moderate to severe AD
5. Nemolizumab was FDA approved in August 2024 for the treatment of prurigo nodularis, addressing the intense itching and nodular skin lesions associated with this condition. (Also being investigated for AD.)

These approvals represent significant progress in expanding treatment options for inflammatory dermatoses, improving patient care and outcomes.

Cosmetic procedures in patients with Skin of Color: Understanding cultural, structural, and biological nuances

Cheryl Burgess, MD, FAAD

Dr. Cheryl Burgess discussed the unique differences and important considerations in evaluating and treating patients with skin of color (SOC). Key physiological differences in SOC include multi-nucleated and larger fibroblasts, lower skin pH, increased melanosomal dispersion, larger mast cell granules, variable blood vessel reactivity, facial pore size differences, and distinct elastic recovery and extensibility of the skin.

Cultural differences also play a significant role in the aesthetic expectations of patients:

- Southeast Asian women often have small faces, large eyes, and V-shaped facial features.
- Middle Eastern patients place great importance on the size and shape of the nose, with rhinoplasties being a common procedure.
- West African women are culturally encouraged to maintain a fuller body shape, sometimes through force-feeding in younger girls to achieve the ideal.
- South Pacific cultures value tribal tattoos, even on the face and lips.
- African American women typically have a 1:1 upper to lower lip ratio, with loss of upper lip volume occurring with age.

Across SOC groups, common concerns include uneven skin tone, infraorbital dark circles, and skin laxity. Regarding pigmentation, Dr. Burgess highlighted the usefulness of a Woods lamp to determine pigmentation depth, noting that epidermal pigmentation is easier to treat than dermal or mixed pigmentation. She also mentioned that pigment production involves 14 steps, with 3 occurring inside the melanocyte and 11 outside, noting that 10 of these steps can be influenced by topical agents.

Dermatosis Papulosa Nigra can be safely treated using a hyfercator (monopolar low mode set at 4.5 watts). For hyperpigmentation and hair removal, the safest laser for SOC patients is Nd:YAG 1064nm, but it is important to always perform a test area first. IPL should be avoided in SOC.

For treating ice pick scars, multiple punctures with a needle can be an effective alternative to more expensive procedures, with good results in collagen production. Radiofrequency is also safe for all skin types but should be applied carefully and slowly in SOC patients for safety.

Dr. Burgess emphasized the importance of understanding both the biological and cultural considerations to provide effective, safe, and culturally sensitive care for SOC patients.

Advances in AD and hyperpigmentation

Speaker: Susan Taylor

Dr. Susan Taylor discussed recent **advances in atopic dermatitis (AD)** and hyperpigmentation in patients with skin of color (SOC). She emphasized the challenges of diagnosing AD in SOC due to clinical variations, particularly the difficulty in identifying erythema. In SOC, the absence of visible redness can mislead clinicians into thinking the disease is controlled when it remains active. To assist in diagnosis, she suggested checking for itching and whether lesions are raised to the touch. Furthermore, the distribution of AD lesions may differ in SOC patients, with follicular, psoriasiform, and lichenoid presentations being more common.

A significant concern in SOC patients with AD is pigmentary sequelae, which often result from the inflammatory process. While genetic factors have been linked to a higher prevalence of AD in SOC, social determinants of health significantly contribute to the disease's severity and burden. Environmental factors, such as air pollution (with Black populations often living closer to highways), and lower socioeconomic status are associated with more severe and persistent AD. Additionally, Black children are less likely to see a dermatologist for AD but are three times more likely to receive an AD diagnosis during those visits, reflecting poor access to and utilization of healthcare among SOC patients.

Regarding AD pathophysiology in SOC, recent research indicates that loss of filaggrin is not necessarily a primary factor in AD for these patients. Instead, it is thought that T-helper 1 and T-helper 22 inflammatory cytokines dominate the disease process. Additionally, ceramide levels have been found to be lower in African American skin compared to White or East Asian skin, with reduced ceramide/cholesterol ratios in African skin as well. In all cases of AD, maintaining microbial diversity on the skin is also crucial.

Treatment of AD in SOC patients remains largely similar to other skin types, though special attention must be given to counselling and moisturizing skincare alongside prescription medications. An ideal moisturizer should include a combination of emollients, occlusives, and humectants to support the skin barrier. Over-the-counter treatments for itch, such as colloidal oatmeal, pramoxine, and menthol, can also be helpful adjuncts to manage symptoms. To prevent post inflammatory pigmentation in AD wearing a sunscreen is of utmost importance.

Understanding **hyperpigmentation in skin of color** (SOC) begins with accurately identifying its cause. Epidermal pigmentation includes conditions such as ephelids (freckles), lentigos (including ink spot lentigos), café-au-lait macules, and pigmentary demarcation lines. In contrast, dermal pigmentation examples include idiopathic eruptive macular pigmentation, lichen planus pigmentosus (LPP), erythema dyschromicum perstans (EDP), pigmentary contact dermatitis (also known as Riehl's melanosis), and dermal melanocytosis. Conditions that involve mixed epidermal and dermal hyperpigmentation include post-inflammatory hyperpigmentation (PIH), melasma, drug-induced hyperpigmentation, LPP, and EDP.

As a general approach:

- Epidermal pigmentation is typically treated with topical agents and procedures.
- Dermal and mixed pigmentation may require systemic treatments and procedures, as topical treatments alone tend to be less effective.

The best results are achieved through a **combination** of topical agents, oral therapies**, and procedures.

Topical agents commonly used for hyperpigmentation include:

- Hydroquinone (though caution is needed to avoid inducing exogenous ochronosis, a condition some consider a phototoxic reaction),
- Topical retinoids,
- Triple combination creams (such as Modified Kligman's formula),
- Azelaic acid,
- Kojic acid,
- Vitamin C, and
- Niacinamide.

Procedures that can enhance treatment include:

- Chemical peels (such as salicylic acid if there is concomitant acne, or glycolic acid),
- Laser therapy (Q-switched Nd:YAG, non-ablative picosecond lasers), though caution is needed to avoid rebound pigmentation, and
- Microneedling.

Newer **OTC ingredients** for treating hyperpigmentation include:

- Thiamidol,
- Cysteamine,
- Silymarin (a flavonoid derived from milk thistle),
- Tranexamic acid (though systemic forms tend to work better than topical ones),
- Lotus sprout extract,
- PATH-3, and
- 2-MNG, a novel ingredient that works by binding melanin precursors to inhibit melanin production.

Dr. Taylor emphasized the critical role of **photoprotection** when addressing hyperpigmentation. It is essential to use a broad-spectrum, mineral-based sunscreen with at least SPF 30 that includes iron oxide (3%) to block visible light. Additional sun protection strategies, such as wearing protective clothing and limiting sun exposure, are also important.

Including an antioxidant in the regimen, such as polypodium leucotomos (the best-studied option), is mandatory, as reactive oxygen species (ROS) contribute to long-standing pigmentation. Dr. Taylor stressed that makeup with sunscreen is insufficient, and applying both a makeup sunscreen and a regular sunscreen does not provide a cumulative SPF effect.

Challenging pediatric cases

Speakers: Candrice R. Heath, and Brandi M. Kenner-Bell

Drs. Candrice Heath and Brandi Kenner-Bell presented a discussion on challenging pediatric cases

The first case focussed on **hair-pulling disorder**, formerly known as Trichotillomania. Children engage in plucking, pulling, twisting, and rubbing their hair, with the scalp being the most commonly affected area, followed by eyelashes and eyebrows. The condition affects children from preschool age to adolescents. It is often an unconscious action, occurring during activities such as falling asleep, watching TV, reading, or doing homework. In younger children, hair-pulling may be linked to thumb-sucking, while older children may exhibit compulsive behaviors such as nail-biting or skin-picking. In more severe cases trichophagia may complicate the condition, when it involves ingesting hair, which may lead to the formation of trichobezoars (hairballs).

Suspect this when you see short, broken hairs of different lengths on a normal scalp (not red or scaly). The patch is often an irregularly shaped, single area on front ½ of scalp - never completely bald. It is usually not painful and may give a sense of pleasure.

Referral for a patient with hair-pulling disorder (trichotillomania) is not always necessary. It depends on the severity of the case and the patient's response to initial interventions. Referral might or might not be needed: if the condition is generally self-limited (especially in younger children), mild cases with episodic hair-pulling that respond well to emotional support and behavioral modification techniques, combined with mild psychological changes (50-75% of cases), and these are manageable without specialized intervention, and cases where there is some evidence of improvement with N-acetylcysteine. Referral should be considered however when severe psychological disturbances are observed (particularly in tweens/teens (~5% of cases), and behavioral interventions alone are insufficient, when there is a need for more advanced treatments such as Cognitive Behavioral Therapy (CBT), if pharmacological interventions (such as tricyclic antidepressants (TCA) like clomipramine or SSRIs) are required due to significant psychiatric comorbidities.

The next case was a boy with **tinea capitis**. They mentioned that T capitis have been reported in newborns and infants! Trichophyton tonsurans accounts for over 90% of cases in the USA, and it is typically transmitted from humans. Another common pathogen, Microsporum canis, is usually transmitted by cats (more often) and dogs. Asymptomatic carriers are considered a major reservoir for these fungal infections. It is important to screen family members and close contacts, as they may carry and spread the infection without showing any symptoms themselves.

Oral therapy is essential for treating T capitis as the medication needs to penetrate the hair follicle to be effective. Griseofulvin is a common choice, with the dosage depending on the formulation (Microsize: 20-25 mg/kg/day for 6-12 weeks; Ultramicrosize: 10-15 mg/kg/day). Absorption is variable and is improved with a fatty meal, but the long duration of treatment often leads to poor adherence. Griseofulvin is more effective for infections caused by M canis. Terbinafine treatment is only for 2-4 weeks which encourages adherence. More effective for T tonsurans (less effective for M canis). Fluconazole is an alternative oral antifungal for T capitis. Treatment is also for 6 weeks. It is the only oral antifungal approved for children under 2 years old. It has better cure rates compared to griseofulvin some cases. Potential medication interactions but still considered very safe for use in children. Itraconazole is not first line treatment. Can use in pulse dosage regime *as per toenail T unguium (ie; 3 pulses).

The third case was a girl with Central Centrifugal Cicatricial Alopecia (CCCA) – yes it happens in pediatric and adolescent patients! Other scarring alopecias can also occur in children. Breakage of the hair is an early sign. Ask the child/teen about symptoms such and pain, tenderness or itching of the scalp. Treat similarly as adults. With time it will progress to permanent loss of hair follicles so treat aggressively. There is no FDA approved treatment specifically for CCCA. Treatment includes topical

and intralesional corticosteroids, oral doxycycline (not under the age 8yrs) and minoxidil (low dose – 2.5mg/day or less – is safe in children). In a patient with chronic scalp pruritus without dandruff think of CCCA. Looking at mom's scalp may help with an early diagnosis.

During the case presentation, a little boy was shown with an asymptomatic hyperpigmented plaque consisting of follicular hyperkeratotic papules on his cheek. The diagnosis was **Follicular Keratosis**, also known as traumatic anserine folliculosis, keratotic papular lesions of the chin, or pressure-induced facial follicular papules.

This condition typically affects the chin, jawline, cheeks, or upper lip, mostly in children and young adolescents with brown or black skin. It is believed to be caused by friction or pressure, with cases even reported due to cell phone use.

Treatment options include:

- Behavioural modifications: Reducing the role of pressure and friction (e.g., mask-wearing).
- Topical retinoids.
- Topical calcipotriol.
- If there is no improvement with topical corticosteroids (TCS) or topical calcineurin inhibitors (TCI), a combination of TCI with a retinoid can be used to reduce irritation.

A case of **periorificial dermatitis** was described. Common in children and young women. Common in children using spacers for inhalation corticosteroids. Blepharitis, conjunctivitis, chalazion, and hordeolum frequently seen with this acneform eruption (no comedones). There is uncertainty of the role of demodex mites. Note: extrafacial involvement of other periorificial sites is possible. Treatment as with adults. (may need prolonged courses of antibiotics – even up to 6 months).

Rosacea can occur in children.

Ended off with some salient points on pediatric chronic skin disorders and stigma. Make sure to get the child's input on the impact on his/her quality of life and not only the caregiver's. This was discussed by looking at the impact of vitiligo in particular, but can also be applied to severe acne vulgaris, atopic dermatitis or other chronic skin conditions. In a cohort of 30 vitiligo patients (8-18yr-olds) 90% of the vitiligo group had at least 1 psychiatric diagnosis vs. 20% in healthy controls. There was a statistically significant difference in anxiety in the vitiligo group vs. healthy controls and rates of ADHD (36.6%) was significantly higher than that seen in the normal population (11.3% for ages 5-17 years in United States). (Clin Exp Dermatol 2021; 64(3):519-515). Remember the long-term impact of the skin disease so do not undertreat.

Diagnosis and management of hair disorders in patients with Skin Of Color

Speakers: Susan C. Taylor, and Amy McMichael

Scarring alopecias

Susan C. Taylor, MD, FAAD

Central Centrifugal Cicatricial Alopecia (CCCA): Two-thirds of cases present with the classical pattern of initially central alopecia that expands centrifugally. However, some typical variants involve not only the central scalp but also frontal, temporal, parietal, and/or occipital areas.

In about one-third of patients, the condition presents atypically, with the most common atypical presentation being patchy hair loss. Other atypical variants include occipital, parietal, frontal, temporal hair loss, and trichorrhexis. These atypical presentations often lead to misdiagnosis or delayed diagnosis, which results in inadequate treatment, contributing to scarring and a significant psychosocial burden.

While CCCA primarily affects women, it also occurs in men and children.

Common dermoscopic features of CCCA include:

- Honeycomb pigmented network
- Absence of follicular ostia with peripilar white/gray halos
- White patches of follicular scarring interrupting the honeycomb network
- Interfollicular small white round macules irregularly distributed, giving a 'starry sky' pattern

Hair shaft variability

Additionally, the top four comorbidities associated with CCCA are:

- Hyperlipidemia,
- Hypertension,
- Obesity, and
- Type II Diabetes Mellitus.

Lichen Planopilaris: Typically one has 3 variants: classic LPP, Frontal fibrosing alopecia and Lasseur Graham-Little Piccardi syndrome. The clinical course is highly variable (insidious or fulminant). Remember to examine the rest of the body for other features of LP (pre, during or post LPP). Dermoscopic features include perifollicular hyperkeratosis and erythema.

(A tip: CCCA more tender and itching; LPP more burning sensation)

Diagnostic clues for FFA:

- Distribution: anterior hairline spreading posteriorly; symmetrical; band like area
- Lonely hair sign
- Eyebrows – thinned or absent (may precede scalp)
- Facial papules (non-inflammatory)
- ‘New hairline’ – hypopigmented compared to old hairline
- Comorbid lichen planus pigmentosus
- Depression of frontal vein
- No forehead wrinkling

- Preauricular folds

Atypical patterns of hair loss with FFA:

- Diffuse zigzag
- Androgenetic alopecia-like
- Pseudo fringe sign
- Cockade-like
- Ophiasis-like

Frontal fibrosing alopecia (FFA) can present in a non-inflammatory manner in various locations such as the sideburns, eyebrows, trunk, and even limbs. Lonely hair sign has been reported on the lower limbs. In some cases, FFA may be strictly confined to the eyebrows, with eyebrow loss often being the first clinical sign. In men, loss of sideburns can be the only presenting feature of FFA, making diagnosis challenging when inflammation is not obvious. Compared to White patients Black patients experience more facial pigmentation and more itching, more frontal recession and develop the condition at a younger age. FFA tends to be less scaly in Black patients vs White patients.

Frontal alopecia after botulinum toxin may be confused with FFA although perifollicular scaling and erythema is absent. The features are more comparable with androgenetic alopecia.

Traction alopecia (TA) can affect any part of the scalp but is more common in temporal and frontal hair margins. Get comprehensive styling history. Fringe sign is sensitive and specific for TA (ie: differentiate from FFA). TA has also been described in Sikh male patients and women wearing hijabs. TA may be associated with pain but may also be asymptomatic. Dermoscopy at later stage shows peripilar casts that indicates continued traction. Broken hairs and black dots, as well as the 'Flambeau sign' (white tracks resembling a torch in the direction of the hair pull) are also typical. Recommending discontinuation is culturally insensitive. Modification may be more beneficial to the doctor-patient-relationship.

Management for scarring alopecias in patients with SOC

Amy McMichael, MD, FAAD

Dr Amy McMichael presented the talk on the management of scarring alopecias.

First-line treatment for FFA includes topical calcineurin inhibitors (CNI)(they have tacrolimus in oil in US) and JAK inhibitors. Intralesional steroids administered every 4-8 weeks are used to address symptoms, and mid-potency topical steroids, which can be increased to ultrapotent steroids in severe cases, are also recommended.

Systemic treatment options include:

- Hydroxychloroquine 200 mg twice a day,
- Doxycycline (not great results according to presenter), and
- 5-alpha reductase inhibitors (for those not of childbearing potential).

Additionally, switching to physical-blocking sunscreens is advised to minimize irritation, although there is no concrete evidence in the literature.

Second-line treatments include Methotrexate and Nd:YAG laser therapy.

Third-line options include Oral corticosteroids, Ciclosporin, and Pioglitazone.

Combination therapies are strongly recommended to enhance efficacy in managing FFA.

CCCA is often accompanied by TA, and predates chemical relaxers.

Goals of Treatment for Central Centrifugal Cicatricial Alopecia (CCCA) is to halt symptoms (pruritus and pain), to explain the inflammatory and progressive nature of the disease to patients and to minimize traumatic behaviours. Furthermore, recruiting remaining hairs back to health, improving the appearance of hair density and maintaining long-term improvement, focusing on disease stabilization and preventing further progression.

Discuss genetic predisposition, decrease traumatic procedures and refer to support groups (Scarring Alopecia Foundation (S.A.F.) – scarringalopecia.org and Skin of Color Society short film (www.skinofcolorsociety.org).

Check whole scalp: if have features elsewhere on scalp then systemic treatment is a better option. During the inflammatory stage moisturizing anti-dandruff shampoos week as well as topical and intralesional corticosteroids is a reasonable place to start. Goal is to be symptom free.

Post-Inflammatory Treatment for CCCA include firstly long-term topical steroids – to reduce ongoing inflammation. Topical and oral minoxidil is added to prolong the anagen phase and promote hair regrowth. Surgical restoration is an option for patients with stable disease who have minimal hair loss. 5-alpha reductase inhibitors may be beneficial, particularly in addressing underlying pattern hair loss.

Emerging Therapies include Platelet-Rich Plasma (but need to continue standard disease otherwise recurs), Low-level laser light therapy and Nutritional supplementation.

Management of non-scarring alopecias

Amy McMichael, MD, FAAD

Dr Amy McMichael continued onto the management of non-scarring alopecias.

Trichorrhexis Nodosa – innate fragility observed in African American patients. May be congenital or acquired. Check for iron and thyroid levels and for nutritional deficiencies. Advise to give the hair a rest; serial trimming of the hair (6-8weeks); use heat protectant products. A moisturizing haircare regimen is advised and includes these steps:

1. Moisturizing Shampoo: Start with a shampoo specifically formulated for dry and damaged hair.
2. Leave-in Conditioner (Dimethicone): After washing, apply a leave-in conditioner to wet hair.
3. Leave-in Conditioner (Oil): Once the hair is dry, apply a second leave-in conditioner. Initially, this should be done weekly, but the frequency can be adjusted as needed over time.

Make sure that the patient is aware of the long wait period.

Androgenetic Alopecia – more than 50% of older men and 15% of postmenopausal women. 2 FDA approved treatments – minoxidil and finasteride.

Treatment: topical minoxidil5%, Low dose oral minoxidil (LDOM); Finasteride 1-5mg/d, PRP, Hair transplantation.

LDOM – much better adherence to treatment. Complications include hypertrichosis vir topical 5% and systemic 15%). Oral minoxidil: 4% had pretibial oedema. Postural hypotension. 3 pericardial effusions described in world literature. Important is to keep in mind that this is a chronic treatment – is like DM medication: if stop it DM will be out of control. So if stop minoxidil hair will fall out again. 'Minoxidil shedding' aka 'dread shed': happens around 4weeks after commencing minoxidil. Takes around 4-6w to slow down. Doses: Adult female 1,25mg; Adult male 2,5mg; Adolescent female 0,625mg; Adolescent male: 1,25mg.

Alopecia Areata (AA) – SALT score is standardised method for measuring scalp hair loss in AA. Earlier treatment has better outcome. Current approved JAK inhibitors: Ritlecitinib (12yrs+), Baricitinib (adults only; can up titrate and down titrate), Deuruxolitinib (chemically altered form of ritlecitinib; studies only in adults; very recent approval). Differential diagnosis for AA includes CCCA/TA/sarcoidosis/DLE/tinea capitis.

In general, should wash hair at least every 10-14days.

Always consider biopsy to confirm diagnosis.

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