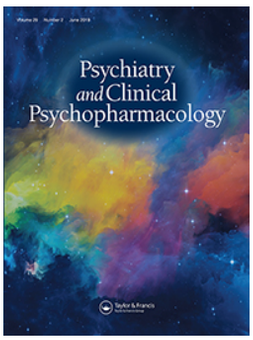

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CASE REPORT

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Three adolescent cases of a very rare disorder: Trichotemnomania*

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ABSTRACT

Trichotemnomania (TT) is characterized as the cutting or shaving of hair, which is an obsessive–compulsive habit. TT takes its name from a fusion of Greek words: thrix (hair), temnein (to cut), and mania (madness). TT is a very rare disease with only five case studies reported in the literature and to the best of our knowledge; no data are available on adolescents. This study focuses on three cases of adolescents with TT. All patients have been evaluated by a dermatologist and two child and adolescent psychiatrists. Dermatological examinations included medical history, physical examination, dermoscopy assessment, and laboratory investigations. Detailed psychiatric assessments consisted of socio-demographic data, clinical history, semi-structured interviews, and psychometric tests. Three cases with TT were both diagnosed with obsessive–compulsive disorder. Two of them diagnosed comorbid social anxiety disorder (in cases 1 and 2), and one case diagnosed with comorbid general anxiety disorder (in case 3) and agoraphobia (in case 3). Cases 1 and 2 were prescribed 50 mg/day of sertraline; however, case 3 refused the treatment. In conclusion, TT may be confused with trichotillomania or other disorders presented with alopecia. Differential diagnoses may be due to histopathological changes or dermoscopic assessment. Dermatologists should consider TT when a supposed alopecia areata looks somewhat unusual and should refer these patients for psychiatric evaluation.

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Adolescent; trichotillomania; obsessive–compulsive disorder; alopecia; trichotemnomania; dermatitis para artefacta

Introduction

Trichotemnomania (TT) takes its name from a fusion of Greek words: thrix (hair), temnein (to cut), and mania (madness) [1]. It is characterized as the cutting or shaving of hair, which is an obsessive–compulsive habit [2]. While trichotillomania has been well known for a century and has been described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) since 1987, TT is a very rare and underestimated disorder [3]. Despite the fact that both trichotillomania and TT are presented with self-induced alopecia, TT patients cut their hair with scissors or a razor instead of pulling it and have an obsessive–compulsive habit, which they are not willing to change [4]. Resistance to admitting the illness is generally common in both trichotillomania and TT. Patients usually feel guilty and embarrassed because of their habit [4]. Although trichotillomania is often well diagnosed and recalled by dermatologists, incidents of TT are often misdiagnosed. In differential diagnosis dermascopy examination generally help the clinician and the presence of follicle openings with filled hair shafts within a healthy-looking range is accepted as a sign for the TT. TT may be confused with trichotillomania or other disorders presented with alopecia. When the literature is reviewed for the TT, there are only a few case reports to be found [1,2,4–6]. To the best of our knowledge, there are no cases of TT in adolescents. This study focuses on three cases of adolescents with TT.

Case presentations

Three adolescent patients with various characteristics of TT attending to dermatology clinic were assessed by a dermatologist and child and adolescent psychiatrists. Dermatological assessment included medical history of patients, physical and dermoscopic examination, and laboratory investigations. Detailed psychiatric assessments consisted of socio-demographic data, clinical history, semi-structured clinical interviews (Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version – Turkish Version), and psychometric tests (Yale–Brown Obsessive Compulsive Scale, Social Anxiety Scale for Children – Revised). All patients were followed up for at least six months.

Case 1

A 15-year-old female adolescent patient was admitted to our dermatology outpatient clinic with a 2-week history of sudden alopecia areata. Dermatological

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*This case series has been presented as poster in 16th ESDAP International Congress in St. Petersburg, on 25–27 June 2015. The abstract of the poster can be found in Acta Dermato-Venereologica (2016, Vol. 96, pp. 140–141).

examination revealed an area over the vertex with broken hairs (with no vellus) as thought they had been cut with scissors or a razor, as all follicles were present but only 2–3 cm long. There was not any medical condition that may explain the hair loss. There was no autoimmune disease history in patient and her family. Her laboratory test resulted normal. There was preservation of normal-length hairs at the margins of the affected areas and over the parietal, temporal, and occipital scalp regions (Figure 1). The patient denied cutting or pulling the scalp hairs. TT was the initial diagnosis and the patient was referred to the department of child and adolescent psychiatry. At the time of examination, she was well groomed and dressed. She articulated herself clearly and answered questions spontaneously. Her affect was anxious. She exhibited normal perception and orientated. There was no psychiatric disorder in her family history. Her mother described herself as protective, anxious, and pessimistic, and she described her husband as obsessive and strict. After caring out detailed psychiatric assessment and questionnaires, she was diagnosed with the obsessive compulsive disorder (OCD) and social anxiety disorder (SAD). Sertraline (50 mg/day) was prescribed for the treatment of OCD. After one year she was symptom-free and medical treatment was discontinued. She was followed up for 1.5 years after treatment was begun and is now in complete remission.

Case 2

A 17-year-old female adolescent patient was admitted to our dermatology clinic with complaints of sudden alopecia, which began one year previously. The patient and her parents claimed that her hair was spontaneously lost. She had been admitted to dermatological clinics several times and was treated for alopecia areata. She did not identify any autoimmune diseases or atopy in her and family history. Her laboratory tests related to alopecia were normal. A close inspection of her scalp has showed irregular 2–3 cm length broken hairs on both sides of parietal and occipital regions. There were no specific dermatological symptoms on her scalp (Figure 2). TT was the initial diagnosis and the patient was referred to the child and adolescent psychiatry clinic. In the first psychiatric interview, she was shy and not communicative. She had mentioned that she had to change her school in the beginning of the year. She had great anxiety in new social situations. Although she was in denial of her behaviour, her father mentioned that she was shaving her hair with scissors. With the help of clinical interviews and psychometric test, she was diagnosed with comorbid OCD and SAD. She was prescribed 50 mg/day of sertraline. After one year she was symptom-free and medical treatment was discontinued. Her followed up visit after 1.5 years she was in complete remission.

Case 3

A 15-year-old female adolescent patient was admitted to our dermatology clinic with the compliant of alopecia in her scalp for approximately two weeks. She had no hair loss on other regions of her body. There were no personal or family histories of autoimmune diseases and thyroid disorders in order to explain the alopecia areata. The serum total T4 and T3, thyroid stimulating hormone, and antibody levels to thyroperoxidase and thyroglobulin were normal. Dermatological examination revealed broken hairs (with no vellus). In fact, the scalp looked like it had been shaved (Figure 3).

Figure 1. Vertex with broken hairs (with no vellus) as thought they had been cut with scissors or a razor.

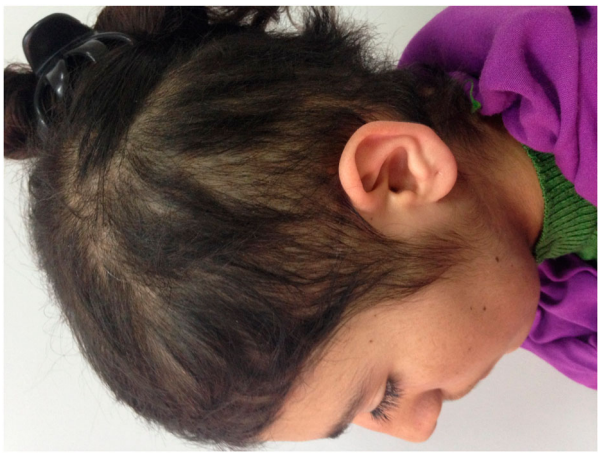

Figure 2. Scalp area showing irregular 2–3 cm length broken hairs on both sides of parietal and occipital regions.

Figure 3. Dermatological examination revealed broken hairs (with no vellus), providing proof that it has been shaved.

Table 1. Characteristics of the patients with TT.

	Case 1	Case 2	Case 3
Age, gender	15, female	17, female	15, female
Appling clinic	Dermatology	Dermatology	Dermatology
Comorbid diseases	OCD, social anxiety disorder	OCD, social anxiety disorder	OCD, general anxiety disorder and agoraphobia
Location of hair loss	Scalp	Scalp	Scalp
Admitted the self-induced mechanism	No	No	No
Treatment	Sertraline 50 mg	Sertraline 50 mg	–
Follow-up duration	1.5 years	1.5 year	Refused to treatment

The patient denied shaving or pulling the scalp hairs. Scanning microscopic examination of hair from the scalp showed that the hair stubs had cleanly cut surfaces. Initially, the patient was diagnosed with TT and referred to a child and adolescent psychiatrist. In her psychiatric interviews, there were not any traumatic life events or illnesses in the patient's life but she displayed some traits of perfectionism. In her family, although her father had OCD symptoms, he was never diagnosed with OCD. At the end of the psychiatric assessment, she received a diagnosis of OCD and generalized anxiety disorder. Her family refused the diagnoses and treatment, and said that they wanted to admit her to a brain surgery clinic (Table 1).

Discussion

In this study, three cases of adolescents with the diagnosis of TT were reviewed. The common characteristics of these three adolescent cases were having a sudden hair loss in their scalp because of cutting or shaving their hair and denial of their habit. Also, three of the patients had comorbid OCD. According to DSM-5, obsession is defined as recurrent and intrusive thoughts which cause anxiety, and compulsions are behaviours or mental acts aimed at reducing these anxieties [7]. Our cases indicated that, when the comorbidity of TT and OCD are taken into account, TT is not purely voluntary; rather, it is performed to relieve stress. Thus, TT may be an obsessive–compulsive behaviour as a result of increased emotional stress. In our cases, as in the literature, although the patients consciously cut their hair, they denied the habit which may cause the clinicians to consider this disorder as a part of a malingering syndrome [8]. Patients diagnosed with TT usually have fair insight into their condition, as they do not worry about alopecia, and compulsively cutting their hair [9]. This may cause misdiagnosis and inadequate treatment of TT, and result in multiple consultations [5]. Denial of their condition may be due to feelings of embarrassment and/or guilt [4].

TT may be confused with trichotillomania which is also known as hair-pulling disorder is characterized by the obsessive pulling of hair and results in alopecia [7]. Currently, in DSM-5, trichotillomania is included in the chapter on obsessive–compulsive and related disorders, along with OCD, excoriation disorder, body dysmorphic disorder, and hoarding disorder. However, TT still does not find a place in current diagnostic classification systems in psychiatry. In dermatology manuals, both disorders classified in dermatoses of primary psychiatric disorders as "dermatitis para artefacta" [8]. TT and trichotillomania both generally occur in scalp region (cases 1–3) with alopecia; however, they can also occur in other hairy regions including the eyebrows, eyelashes, axilla, or pubis [5,8]. Differential diagnoses of TT may be due to histopathological changes or dermoscopic assessment [2]. TT shows entirely normal histological structures and cleanly cut surfaces. The presence of follicle openings with filled hair shafts within a healthy-looking scalp is diagnostic key for TT [4].

Another type of hair loss with associated psychiatric comorbidity is Trichoteiromania. Trichoteiromania is characterized by breaking the hairs by rubbing or scratching the scalp in a repetitive way [10]. It may be confused with TT as it presents with bald spots and hairs of different lengths. Differential diagnosis can be made with light microscopy of the hair shafts showing brush-like splitting of the ends [10]. Trichodaganomania is also mentioned in the literature and is associated with psychiatric disorders. It is a compulsive habit of biting one's own hair; however, there is no hair loss on the scalp [11].

TT is a very rare disease and psychiatric diagnostic manuals still do not include TT. When we searched for "Trichotemnomania" in the literature, we found only a few references [1,2,4–6,8]. Dermatologists and psychiatrists do not recognize this clinical entity, and most cases are left undiagnosed. We suggest studying the clinical characteristics of TT with large samples, as such studies are lacking in the literature. In conclusion, dermatologists should consider TT when a supposed alopecia areata looks somewhat unusual, and following dermatological examination, should refer patients for psychiatric evaluation.

Disclosure statement

No potential conflict of interest was reported by the authors.

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