



Letter to Editor

Successful Clinical Treatment in a Case of Lichen Planopilaris after Hair Transplantation

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Letter to Editor,

Lichen planopilaris (LPP) is lymphocytic cicatricial alopecia [1]. The etiology of LPP is not known. Many authors regard such a condition as a hair-specific autoimmune disorder in which T-lymphocytes target follicular antigens with subsequent destruction of the hair follicle stem cells of the bulge [2]. Meanwhile, recent evidence indicates that follicles with an apparently normal appearance in patients with LPP and Frontal Fibrosing Alopecia (FFA) may have subclinical perifollicular inflammation [3].

Hair transplantation (HT) is controversial in primary scarring alopecia. Positive and negative results have been reported in LPP and FFA [4]. Furthermore, could be a trigger for LPP activation in patients with subclinical or stable disease.

We report the case of a 45-year-old man who presented clinical, trichoscopy and histopathological features of LPP after 2 years of hair transplantation (Figure 1).

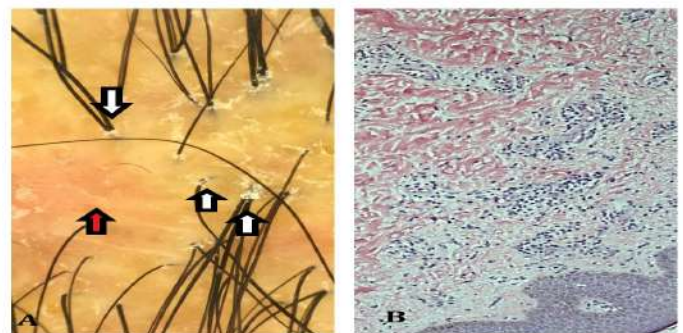


Figure 1: Trichoscopy and histopathology; **A)** (white arrows) perifollicular scale and (red arrows) milky red areas; **B)** (H&E) Perifollicular inflammation and lack of hair follicles.

He was using 1mg of finasteride, topical minoxidil and anti-dandruff shampoo. We started treatment with hydroxychloroquine 400mg/day, topical clobetasol 5x a week and oral minoxidil 2.5mg/day for 3 months with a satisfactory response with hair regrowth in the area of alopecia and clinical stability of the disease (Figure 2).



Figure 2: A) Before the hair transplant; B) 14 months after the hair transplant;

C) 24 months after the hair transplant at that moment we started the treatment for LPP;

D) Good cosmetic result after starting the LPP treatment.

We performed a biopsy of the temporal area where the transplant had not been performed. Therefore, we excluded the possibility that these findings were post-transplant. We hypothesized that the patient had subclinical lichen planus before surgery and androgenetic alopecia, so he had good results with hair transplantation initially. However, surgery may have been a trigger to developing a clinical case of lichen planus. Proper diagnosis and treatment were essential for hair regrowth and to maintain post-transplant results.

It is very important for the hair transplant surgeon to identify differences between clinical and trichoscopy signs of LPP, Fibrosing Alopecia in a pattern distribution (FAPD) and AGA because this may mean avoiding the HT in patients who have active LPP. However, in cases where the patient has subclinical LPP, doing the diagnosis before hair transplantation is a challenge. We recommend assessing hair growth from the 12th month after hair transplantation. If it is insufficient and the patient has related symptoms to LPP, we could evaluate whether the LPP would be confirmed by trichoscopy and biopsy. A recent study demonstrated that is controversial to perform a biopsy before one year in the recipient area since the histopathology can be very similar in normal hair transplants having lymphocytic infiltrate and fibrosis as occurs in LPP for that [5]. As shown in this case, in suspected cases of LPP after hair transplantation, is essential to carry out early diagnosis and treatment to maintain the outcomes. In the case of a non-transplanted area being affected, taking a biopsy of that area would be the most appropriate.

References

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