Atypical presentation of Trichotillomania: a case report with review of the literature

Présentation atypique de la trichotillomanie : un cas clinique avec revue de la littérature

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ABSTRACT

Trichotillomania is a chronic mental illness with an elevated rate of psychiatric comorbidities. Patients with Trichotillomania often have a low insight putting them at risk for serious health problems such as depression, social dysfunction, body damage, malnutrition, even death in severe cases if untreated. Not all patients have access to health care, most of them live in difficult environments with different cultural variations and attitudes toward mental illness making them more vulnerable. The literature suggests that there is a variety of psychotherapies and medications that may help in managing Trichotillomania. The present case is of a woman with no prior history of mental illness, who was brought by her father for behavioral issues. During her evaluation we observed various symptoms associated with different pathologies, exemplifying the difficulties to diagnose individuals with Trichotillomania and to prepare a treatment plan for them.

Keywords: Trichotillomania, Mental health, Psychiatry, Psychological distress.

RÉSUMÉ

La trichotillomanie est une maladie mentale chronique avec un taux élevé de comorbidités psychiatriques. Les patients atteints de trichotillomanie ont souvent une mauvaise conscience de leur trouble, ce qui les expose à des problèmes de santé graves tels que la dépression, le dysfonctionnement social, les dommages corporels, la malnutrition, voire la mort dans les cas graves s'ils ne sont pas traités. Tous les patients n'ont pas accès aux soins, la plupart d'entre eux vivent dans des environnements difficiles avec des variations culturelles et des attitudes différentes à l'égard de la maladie mentale, ce qui les rend plus vulnérables. La littérature suggère qu'il existe une variété de psychothérapies et de médicaments qui peuvent aider à gérer la trichotillomanie. Le cas présent est celui d'une femme sans antécédents de maladie mentale, qui a été amenée par son père pour des problèmes comportementales. Au cours de son évaluation, nous avons observé divers symptômes associés à différentes pathologies, illustrant les difficultés à diagnostiquer les personnes atteintes de trichotillomanie et à préparer un plan de traitement pour elles.

Mots clés : Trichotillomanie, Santé Mentale, Psychiatrie, Détresse psychologique.

INTRODUCTION

Trichotillomania (TTM) is a condition characterized by ritual repetitive pulling out of one's own hair, leading to a noticeable hair loss and marked functional impairment (1).

According to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, fifth edition), TTM is now included in the chapter on Obsessive-Compulsive and Related Disorders with obsessive-compulsive disorder (OCD), excoriation disorder, body dysmorphic disorder, and hoarding disorder. The diagnosis is based on clinical and history of psychiatric illness (2).

This type of patient rarely seeks professional help and ends up with a disabling disorder (3).

There are many health Consequences due to trichotillomania such as trichophagia a condition characterized by gastrointestinal obstruction and the formation of intestinal hairballs (trichobezoars) requiring surgical intervention in extreme cases (4).

When suspected, a rigorous medical assessment must be done. An abdominal CT scan and all other biological explorations can help in the search for eventual complications (5).

There are no guidelines on how to treat pharmacologically TTM, but certain molecules have promising results (3)(5)(6).

This case highlights the challenges confronting psychiatrists on a daily basis giving the unspecific symptoms and noncompliance of patients.

OBSERVATION

We present a case of a forty-year-old female who is single brought to our consultation by her father. She was living poor in an isolated village in western Algeria. She was uneducated with no history of mental health problems in her family.

Her father describes her as very isolated, always in retreat compared to her siblings with very limited social interaction. He declared that

those seeking a medical opinion regarding mental health problems in his community are often stigmatized.

The patient said that she has no medical or mental problems, that she does not suffer from anxiety or other psychological distress. There were no indications of substance misuse and did not report any death wishes or suicidal ideations.

From her presentation, we can see that she appears to be skinny with a cadaveric face wearing a hijab, with what looks like a deformity on top of the head. We suspected malnutrition and there were no stereotyped movements.

Examining her head, we noticed a large area with hair loss (**figure 1**), that was covered with the rest of the hair like a camouflage. She did not seem to have any signs of embarrassment or discomfort and was undisrupted by the alopecia.

Figure 1. Picture representing the scalp of the patient with a large region of incomplete hair loss.

During the mental evaluation we noticed a reticence in her speech with short and very limited answers, we did not observe any delusional thoughts or hallucinations nor any obsession with her physical appearance.

When the patient describes her daily activities, we detected apathy, never participates in pleasurable activities with minimum interaction with the family, she eats all her meals alone away from the eyes of others.

The patient admits having moments of irritability and agitation due to the pressure from her family but without being physically aggressive. Her father reported that she didn't sleep at night and stays awake but ignores what she was doing. We noticed a complete indifference regarding her symptomatology, didn't express any sadness, worries, feelings of shame, or guilt.

She has declared not aware of her hair pulling, she wasn't able to give any reasons for her hair pulling or what were the triggers for her compulsive behavior; like the feeling of tension, gratification, or relief after completing the pulling. We did not find any signs of pulling in other areas and denied ingesting her hair.

The physical exam was without any particularity and did not report any gastrointestinal problems. The laboratory work revealed elevated free thyroxine (FT4), megaloblastic anemia, and hypokalemia. She weighed: 35kg with a Body mass index of 14,1.

We ordered an electrocardiogram, cervical ultrasound, an abdominal CT scan, vitamin B dosages.

The diagnosis impression was of TTM, taking under consideration the anamnestic elements and the clinical presentation that was not enough to fulfill the criteria of DSM-5, opening the door for other differential diagnoses and possible comorbidities.

The patient refused psychotherapy because of transportation difficulties and consented to affordable pharmacological treatment. We prescribed Clomipramine with a starting dose of 25mg a day, Prazepam 10mg a day, vitamin B complex supplementation, surveillance of all parameters, and medications tolerability. We referred her to the general medical care for her somatic disorders and eventually deeper explorations.

The patient was seen three weeks later but didn't take her medications correctly, yet she reported an improvement in her sleep. There was no decrease in hair-pulling behavior.

We concluded that there is a Complete absence of insight in this patient making it very difficult to establish a strong therapeutic alliance. Despite that, we tried to keep in touch with the patient and her family.

DISCUSSION

Hair pulling involves many regions of the body, the scalp is the most common site in trichotillomania (1)(5). It is a rare condition as isolated disorder, with a female predominance and most often at an early age which are sensitive years for development (1)(7)(8).

It is worth mentioning that some authors described three subtypes of pulling: early-onset, automatic, focused (9). Identifying the type of pulling may help in treatment decision-making (1).

The awareness of hair-pulling and the occurrence of tension or relief may depend on mood and specific situation (9).

Researchers found that 20% of patients eat the hair after pulling it (trichophagia), plus it can form hairballs that can result in abdominal pain, vomiting, weight loss, intestinal obstruction (trichobezoar), which may require surgical intervention in severe cases (5). Deterioration of the general condition can be found (9), as we observed in our patient. Systematic assessment is needed for those presented with hair pulling.

Other studies found that Patients with trichophagia are more seriously ill than individuals without trichophagia, this behavior may develop later complications and can affect treatment outcomes, suggesting that clinicians should be careful while exploring it (10).

The neuroimaging of affected individuals suggests alterations in brain regions responsible for the affect, motor habits, and cognition. The Biopsy should be done only in doubtful cases of the etiopathology of the alopecia (11).

The diagnosis of TTM is based on the clinical manifestations, medical and psychiatric history of the patient (11). Therefore, it is necessary to exclude other medical and psychiatric conditions for a proper diagnosis.

Comorbidities are very common in TTM and are associated with OCD, impulse-control, personality disorder, and eating disorders (1)(8)(9).

A number of issues can be identified leading to diagnosis confusion. First, some publications suggest that not all clinical characteristics are present specifically in all patients, there are concerns involving criteria B (tension before pulling) and

(reduction in tension after pulling) in the **Diagnostic and Statistical Manual of Mental Disorders in its fourth revised** edition (DSM IV-TR) ruling out many individuals who suffered from hair-pulling (12).

Second, twenty percent of patients did not report a sense of tension related to hair pulling if we refer to Criteria B of DSM IV-TR suggesting having its limitations for diagnosis (13). There is no difference in hair pulling severity between patients who meet the criteria of DSM-5 compared with those who do not (12)(13).

Part of the complexity of this case is around how well functioning the patient was, and at what time different symptoms started.

From a differential diagnosis perspective, the initial impression was of an eating disorder. However, the assessment reflected the presence of a probable psychosis although signs of dissociation were not present as might be expected.

Subjective and objective symptoms could also be in favor of a diagnosis of personality disorder, mood disorder, anxiety disorder, dermatological condition, psychiatric pathology due to a medical condition.

As mentioned before not all clinical presentations fit a diagnosis and may settle with a description of a presenting problem that do not have a DSM or international classification of diseases (ICD) label.

There are some pharmaceutical recommendations, considering the nature of the disorder and the severity of the symptoms. Several drugs from different classes like antidepressants, antipsychotics, glutamate modulators, opioid antagonists, revealed some promising results and may also help when targeting comorbid symptoms (3).

Clomipramine demonstrated some benefit on behavioral patterns in some cases (1, 6), while Olanzapine showed some benefit versus placebo in a double-blind placebo-controlled trial. N-acetylcysteine (NAC) demonstrated some benefit at 1200mg a day, reducing the symptomatology (3). The analysis of Naltrexone trials indicated that it could reduce the pulling behavior in patients suffering from TTM with a history of substance misuse (1, 3).

Some psychotherapies are approved by experts such as Habit reversal training (HRT), having the most evidence of efficacy as first-line treatment (8), but relapse could occur (1, 3, 14).

Taking photographs before initiating treatment could be helpful during treatment to estimate the changes afterward (1).

From some case series, *repetitive transcranial magnetic stimulation* (rTMS) was used as treatment and observed substantial benefit in some patients (15).

The interpretation and analysis of such clinical presentations are challenging, requiring further deep investigation for an accurate treatment plan, despite that, it remains complicated since there are no FDA-approved drugs for TTM.

CONCLUSION

The strong comorbidity in TTM with other psychiatric conditions can be easily misdiagnosed, additionally, it is difficult to treat poorly motivated and financially disadvantaged patients. Reporting more cases may result in case series and ultimately help in understanding these pathologies. It is still necessary that the treatment should be individualized, and further investigations may still be needed in this specific area of clinical psychiatry.

Conflict of interest

The authors declare that they have no conflict of interests.

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