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Alopecia Areata and Comorbid Conditions

Should We Screen Patients?

Comorbidity is an emerging issue in dermatology, with increasing evidence that common dermatological diseases, such as psoriasis, can be associated with systemic conditions that severely affect patients' health and even their life expectancy.

The study reported by Huang and coworkers[1] in this issue shows that alopecia areata (AA) is commonly associated with autoimmune diseases, atopic dermatitis, and psychiatric problems. This is not new information; most of these associations have been well known for more than 50 years. In 1963, Muller and Winkelmann[2] published in this journal a retrospective study of 736 patients with AA seen at the Mayo Clinic from 1945 to 1954. Comparing the results of the 2 studies, we see the same comorbid conditions reported, even if the prevalence is considerably higher in the current study for most conditions, as follows: atopy, 11% for Muller and Winkelmann[2] vs 38.2% for Huang et al[1]; psychiatric disorders, 18% vs 25.5%; thyroid diseases, 8% vs 14.6%; diabetes mellitus, 2% vs 11.1%; vitiligo, 4% vs 2.8%; collagen diseases, 2% vs 8.2%; and ulcerative colitis, less than 1% vs 6.3% for inflammatory bowel disorders.

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The first practice gap is the need to understand whether this increase is real or just linked to advances in diagnostic methods or differences in the study population and methods. For some conditions, the increase is probably real; for instance, there is strong evidence that the prevalence of atopy is increasing.

The second practice gap is the need for dermatologists to include in their review of systems for AA questions about autoimmune disorders, mood or depression, and bowel symptoms. The association of AA with psychiatric disorders is very well known; most patients report that the disease was triggered by a stressful event, and there is evidence that AA has a considerable effect on quality of life, being much more debilitating than its inherent clinical severity. Shared care of patients with a psychiatrist is highly recommended.

The third and most important practice gap for physicians is establishing the costs and benefits of ordering extensive laboratory and diagnostic tests to screen patients with AA for possible associated autoimmune diseases. Such screening will not only significantly increase health care costs for these patients but will also increase anxiety in a patient population already characterized by anxious-depressive traits.

To close this gap, we need to estimate the effect of these comorbid conditions on the health and health care costs of patients with AA. Patients with AA are usually in good physical health, and, to my knowledge, there are no data suggesting that they have increased risk of serious diseases or reduced life expectancy. We have no evidence now suggesting that routinely screening patients with AA for associated disease will prevent or reduce morbidity.

A recent population study in Taiwan[3] evaluated comorbid conditions in 4334 patients with AA using medical diagnostic codes. Stratification of comorbid conditions by age groups showed that disease association and tests to order may depend on the patient's age: for example, screening for thyroid diseases is not useful in children and is useful only in patients older than 20 years. If these data are confirmed by similar large studies in different populations, physicians will have enough information to select a few specific tests instead of a large unselected panel.

Evaluating the effects of comorbid conditions on the health care costs of AA will require a specific study, as has recently been done for psoriasis.

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