Unusual case of bilateral ciliary madarosis: trichotillomania

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DESCRIPTION
Trichotillomania is an impulse-control psychiatric disorder characterised by compulsive plucking and removal of body hair. The commonly involved sites are scalp, eyebrows, eyelashes and pubic hair. Here, we present this unusual case of bilateral ciliary madarosis.

An 18-year-old female patient presented to an ophthalmology Out Patient Department (OPD) with complaints of loss of eyelashes for the past 3 weeks. On further enquiry, her parents informed her that patient herself plucks the eyelashes whenever they grow. The patient complained of intense itching, for which she removed the eyelashes and trimmed some with a pair of scissors, followed by relief of symptoms. There was no history of any dermatological disorder or psychiatric disorder in the past or in the family. There was no history of any systemic medication.

On general examination, the patient was alert, conscious and co-operative with stable vitals. There were no obvious signs of hyperthyroidism, malnutrition or any dermatological disorder. On ophthalmological examination, the eyelids appeared thickened with patches of absent lashes along with patches of broken short cilia at different levels. Several signs such as black dots indicating broken hair, V sign corresponding to two broken hairs arising from one pilorifice and tulip sign showing tulip flower shaped hairs were suggestive of trichotillomania (Figure 1). The hair pull test was negative, which would otherwise be present in alopecia areata (AA). Visual acuity was 6/6 in either eye. The conjunctiva, anterior segment and posterior segments were within normal limits on slit-lamp examination. Blood investigation revealed a normal haemogram, erythrocyte sedimentation rate, serum electrolytes and thyroid profile.

On slit-lamp examination, the patient showed a normal reflex of light. The iris, lens and posterior segments were within normal limits. The anterior segment examination revealed few hair follicles and broken hairs along the lash margins. Although our patient showed signs suggestive of trichotillomania, it was not possible to state that this was trichotillomania, as she was not cooperative with hair pull test. However, she admitted that she plucks the eyelashes when they grow. The patient was diagnosed as having trichotillomania and started on bimatoprost application and behaviour modification training.

Based on clinical history of voluntary pulling and clinical signs, a diagnosis of trichotillomania was made. The patient was sent to the psychiatry department for commencing psychotherapy and behaviour modification training.

Ciliary madarosis or milphosis is a form of alopecia wherein there is loss of eyelashes. The common causes of ciliary madarosis include blepharitis, seborrheic dermatitis, atopic dermatitis, xeroderma pigmentosus, hyperthyroidism and AA.

Among blepharitis, anterior blepharitis is associated with milphosis most commonly. It is characterised by symptoms of itching, burning, foreign body sensation and photophobia. On slit-lamp examination, scruff, collarettes and sleeves are seen along the lash margins. Although our patient had a history of itching and foreign body sensation, there were no clinical signs; thus, blepharitis was ruled out. AA is another common differential that should be considered in cases of itching associated with loss of eyelashes. In AA, there were no clinical signs. However, the absence of clinical signs hinted more towards a psychiatric disorder.

Trichoeremnomania is a psychiatric disorder where the affected individual has a tendency or shaving and trimming of hair. Our patient had both trichotillomania and trichotemnomania. However, the absence of clinical signs hinted more towards a psychiatric disorder.

Trichotillomania in children usually has a benign course which is precipitated by stressors such as sibling rivalry, lack of parental affection and nocturnal enuresis. Trichotillomania in preadolescents to young adults, which is the common age of presentation, tend to have chronic and relapsing courses. N-acetyl cysteine, tricyclic antidepressants and selective serotonin uptake inhibitors have shown good response. If trichotillomania is associated with pre-existing depression or bipolar disorders, it should be managed accordingly. The mainline of management of trichotillomania involves behaviour modification therapies primarily given by psychologists and in certain scenarios, topical bimatoprost application has been attempted.

To the best of our knowledge, this is the first such case of bilateral ciliary madarosis to be reported post trichotillomania.
Images in...

Patient’s perspective

I am grateful that my doctors could identify the underlying cause and provide me a timely help for possible recovery.

Learning points

► Early diagnosis of underlying trichotillomania helps in early and fruitful management.
► It requires multidisciplinary approach by ophthalmologist, psychiatrist and psychologist, for a comprehensive outcome.

Contributors

DD and SA were the primary point of contact of the patient and the operating surgeons. They also helped in critical revision of the article. MS helped in collecting data and clinical images of the patient and review of the literature. SM drafted the article.

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Competing interests

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Consent obtained directly from patient(s).

REFERENCES


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