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 pilar orifice 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.

Figure 1 Clinical picture of the patient showing bilateral patchy absence of hair and patches of small broken cilia.

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.[1] The common causes of ciliary madarosis include blepharitis, seborrheic dermatitis, atopic dermatitis, xeroderma pigmentosa, hyperthyroidism and AA.[2–5]

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.[2] 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 exclamation mark is seen and occasionally white hair can also be noted. Even though trichotillomania is commonly seen in upper eyelid as compared with both eyelids in AA, in present case, both eyelids showed loss of eyelashes. In cases where even clinically AA cannot be differentiated from trichotillomania, a biopsy is indicated.[6] Trichotemnomania is a psychiatric disorder where the affected individual has a tendency or shaving and trimming of hair.[1] 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.[7] 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.[8] 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.[1 9] To the best of our knowledge,[10] this is the first such case of bilateral ciliary madarosis to be reported post trichotillomania.

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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.

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