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Case report

An interesting case of trichotillomania in a pre-school child

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Abstract

Trichotillomania is relatively uncommon in pre-school children, though few case reports mention in children as early as 18 months of age. We report an interesting case of trichotillomania in a two year old female child, who showed gradual improvement on behavioral intervention in the form of bandaging fingers along with Selective serotonin reuptake inhibitor (syrup Fluoxetine).

Keywords: Hair pulling, Trichotillomania, pre-school child

Introduction

The term Trichotillomania (TTM) was first described in 1889 by French dermatologist Francois Hallopeau from the Greek words thrix (hair) tillein (pulling) mania (madness) [1]. Trichotillomania is a chronic disorder characterized by irresistible urge for pulling out of hair from any part of the body that leads to noticeable alopecia [1]. It is commonly seen in the age group of 9 --13 years with the prevalence being 0.6% to 3.6% [2]. It is relatively uncommon in pre-school children though there are few case reports in children as early as 18 months of age [3]. The gender ratio is skewed more towards women at 10:1 but in children no such preponderance is observed [2]. This disorder is incorporated in the fifth edition of The

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) into obsessive –compulsive related disorders [4].

Case report

A 2-year-old girl child from a rural background of Chandrapur district was brought to our Psychiatry Outpatient Department by her mother with complaint of a patch of noticeable hair loss from her scalp of 3 months duration. Three months back mother noticed that her child was having hair loss from her scalp. Initially she was taken to a dermatologist. On examination by dermatologist no dermatological cause was found for patchy hair loss hence the child was referred for psychiatric evaluation. During psychiatric evaluation it was found that the child had an urge for hair pulling. Her mother initially tried to deal with this behaviour by resisting her behaviour "No, don't do that!" “It’s not good” and likewise. That approach didn't work at all and child continued with her hair pulling behaviour. There was no history of hair pulling from other parts of the body, no history of eating the pulled hair or of any abdominal symptoms. She had no habits of thumb sucking or nail biting. The child was born out of no consanguineous marriage. She had attained age appropriate milestones of development. There was no history of similar complaints in her siblings. There was no history of any obsessive compulsive disorder in the family. There was ongoing domestic stress in the family in the form of alcoholic father with repeated physical violence towards mother in an alcohol intoxicated state. The child was afraid of him and used to become anxious whenever he used to return home. Her hair pulling used to increase significantly at that point of time. On examination she had three patches of hair loss on the vertex of her scalp of 2-2.5 inches in diameter. Hairs were sparse, short and unequal in length and irregularly coiled with split ends. No other definite psychopathology could be elicited on

mental status evaluation. She was diagnosed as a case of TTM. At this point, IQ was 85 and her adaptive skill was age appropriate. Picture of the affected area couldn't be taken in time.

Initially mother was asked to observe the child's hair pulling behaviour and note when she was pulling her hair. Mother noticed hair pulling while watching television and lying down on bed before sleeping. Behavioural intervention in the form of bandaging the fingers before going to bed and while watching television was advised. Mother tried to follow the behavioural intervention but consistency was poor. Mother was counseled regarding importance of consistency for getting results with behavioural interventions during each visit. Father accompanied the child to OPD in 2-3 occasions. He was counseled regarding need for abstinence from alcohol. His motivation to quit alcohol was poor. He didn't report for further follow up in spite of repeated persuasion through wife. As no improvement was observed by the behavioural technique during subsequent visit, Syrup Fluoxetine 2ml (8mg/day) in the morning was started, which was subsequently increased to 5ml (20mg/day) over next 8 weeks along with behavioural techniques. Though initially slow improvement was noted; over next 3 months, there was a significant improvement in her hair pulling behaviour. She was maintaining improvement on subsequent follow-up over last six months. There was no new patch of hair loss and hair started appearing in the old patches. Medication will be continued for further period of six months and subsequently dose will be reduced and stopped depending on the response.

Discussion

Based on the bimodal age of onset, TTM is classified into two groups: early-onset and late-onset. Early onset TTM begins at 2–10 years of age, is commoner in boys (62%), and has a benign self-limiting course [5].In this group, TTM is associated with other co morbid conditions such as nail biting, thumb sucking, and skin picking. In our patient no such behaviour was noted. Childhood

onset TTM is typically of short duration with resolution often occurring on its own or with simple interventions. But in our case no such improvement was noticed on behavioural technique.

Non-pharmacological treatment in the form of behavioural or supportive family and professional counseling should be considered first-line therapy for children with TTM, with little work done in this area for the young children with TTM response to behavioural intervention [6]. This was particularly important in our case as her symptoms were associated with ongoing stress in the family.

Pharmacotherapy should only be used as adjunct therapy as no control pediatric trials have been performed. Selective Serotonin Reuptake Inhibitor (SSRIs) are the most commonly used pharmacotherapy for TTM; the rational being similarities between TTM and OCD.

To conclude**,** we describe a case of hair pulling behaviour in a 2 year old pre-school going female child associated with significant domestic stressor in the absence of any comorbid psychiatric condition. She showed substantial improvement on treatment with behavioural technique along with SSRI (syrup Fluoxetine). On subsequent follow up over last six month she maintained improvement and it is planned to continue the therapy as per the standard guideline.

Conflict of interest: None declared

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