For UK healthcare professionals only. This content has been initiated and funded by Pfizer Ltd.

Assessment of alopecia areata

Introduction

Alopecia areata (AA) is a clinically heterogeneous, immune-mediated inflammatory disease characterised by non-scarring hair loss that affects ~2% of the population.[1]

The emotional and psychological impact on individuals with AA can lead to an increased risk of depression, anxiety, reduced self-esteem, altered self-image, social withdrawal, and the breakdown of personal relationships.[2,3]

Making a differential diagnosis – what to rule out

Patchy	Diffuse
Trichtillomania	Telogen effluvium
Tinea capitis	Androgenetic alopecia
Scarring alopecia	

Aspects of the history and examination that give guidance on prognosis

Factors assessed as part of the patient's history can indicate the likely progression of AA, including:

- Family history of AA[4] – 20% of patients[5]
- Younger age at onset (aged <12 years)[6,7]
- Concurrent atopic disease[5]

The initial assessment of AA also provides clues:

- More extensive disease at onset[6]
- Nail involvement – approx. 10–15% cases that are referred to dermatologists[6,7]
- Ophiasis subtype (band-like hair loss along the back and sides of the head)[7]

Medical photography and dermoscopy (trichoscopy)

Medical photography – document the extent and location of hair loss[8]

- Conduct regularly during follow up to note changes
- Ensure sufficient resolution of images[9]

Dermoscopy – examine with a dermatoscope to confirm the diagnosis

- Identifies common features of the condition – dystrophic "exclamation mark" hairs with fractured tips; cadaverised hairs and short vellus hairs[5,6]
- Identifies common indications of active disease – e.g., regular round black dots[5]

Sites affected – AA is not limited to just the scalp

The first site affected is usually the scalp, but all hair sites can be affected:[6]

- Eyebrows and eyelashes – may be only sites impacted – Can prove problematic with loss of physical barrier protecting eyes from particles[6]
- Beards – more apparent in patients with darker hair[5]

In some patients the nails are also affected – look for longitudinal striations, stippled pitting or less well-defined roughening[5]

Using the SALT score to define alopecia areata severity[10]

The Severity of Alopecia Tool (SALT) was developed to standardise the quantification of hair loss across the different quadrants of the head.[10] The SALT score is computed by measuring the percentage of hair loss in each of the four areas of the scalp (see Figure 1):

- Vertex (40%)[10,11]
- Right side (18%)[10,11]
- Left side (18%)[10,11]
- Posterior (24%)[10,11]

The percentage of hair loss in any of these areas = percent hair loss × percent surface area of the scalp in that area.[10]

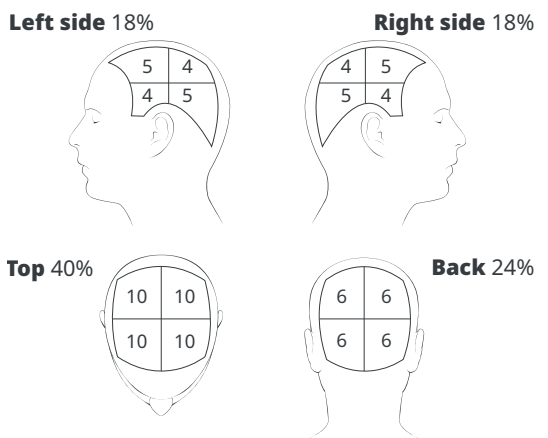


Figure 1 *Tool for estimating percentage scalp hair loss adapted from Olsen et al[12]*

For example, a SALT score of 30 would indicate 30% hair loss. The percentage of hair loss dictates the severity of the disease, categorised as: S_0 = no hair loss; S_1 = 1–24% hair loss; S_2 = 25–49% hair loss; S_3 = 50–74%; S_{4a} = 75–95% hair loss; S_{4b} = 96–99% hair loss; S_5 = 100% hair loss.[10] Percentage hair loss can be corroborated by image analysis, if desired.[10]

- Percentage change from baseline can be used to track response to treatment. The percentage change can be noted as subscript (i.e., a 25% improvement would be $SALT_{25}$)[12]

Testing for AA activity – the hair-pull test

Monitoring for AA activity can be done non-invasively using the hair-pull test:

- A small selection of hair (20–60 strands) is held securely and pulled away from the scalp. A result is considered positive if >10% of the hairs are removed[7,13]
- Identification of dystrophic anagen or telogen hairs during a positive pull test at the border of an existing patch suggests the AA is active[7,14]
- Progressive disease is indicated by a positive pull test from areas of the scalp deemed clinically non-affected[18]

When to biopsy

AA is largely a clinical diagnosis. Very occasionally, biopsy may be indicated where there is diagnostic uncertainty e.g., is it AA or early scarring alopecia?

When indicated, it is recommended to use two 4-mm punch biopsies for horizontal and vertical sectioning.[15,16] The biopsy should be taken from the edge of a lesion at a site that is normally resistant to androgenetic alopecia.[17]

More than hair loss – impacts on mental health and quality of life

Patients' quality of life (QoL) is significantly impacted by AA; however, it is an area that is often not given significant consideration.[6] Depression and anxiety are comorbid conditions that can be associated with AA.[14] Recognition by physicians of the impact of AA on QoL and mental health is essential. Physicians should consider appropriate psychiatric evaluations and the need for professional support for their patients.[18] In addition, the role of patient support organisations and charities should not be overlooked.[18]

Listening to patients is key and assessment tools can be used to gauge the impact of AA on other areas of their lives. Patient-reported outcome measures, can be used to measure the impact of symptoms on patients with AA in a reliable fashion.[19]

References

1 NICE CKS. Alopecia areata: How common is it? Published online 2023. Accessed Feb 9, 2026. https://cks.nice.org.uk/topics/alopecia-areata/background-information/prevalence/ **2** Edson-Heredia E, Aranishi T, Isaka Y, et al. Patient and physician perspectives on alopecia areata: A real-world assessment of severity and burden in Japan. *J Dermatol*. 2022;49(6):575-583. doi:10.1111/1346-8138.16360 **3** Sellami R, Masmoudi J, Ouali U, et al. The relationship between alopecia areata and alexithymia, anxiety and depression: A case-control study. *Indian J Dermatol*. 2014;59(4):421. doi:10.4103/0019-5154.135525 **4** Wang S, Ratnaparkhi R, Piliang M, Bergfeld WF. Role of family history in patchy alopecia areata. *Dermatol Online J*. 2018;24(10). doi:10.5070/d32410041734 **5** Messenger AG, McKillop J, Farrant P, et al. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. *BJD*. 2012;166(5):916-926. doi:10.1111/j.1365-2133.2012.10955.x **6** Pratt CH, King LE, Messenger AG, et al. Alopecia areata. *Nat Rev Dis Primers*. 2017;3. doi:10.1038/nrdp.2017.11 **7** Cranwell WC, Lai VWY, Photiou L, et al. Treatment of alopecia areata: An Australian expert consensus statement. *Aust J Dermatol*. 2019;60(2):163-170. doi:10.1111/ajd.12941 **8** Ramos PM, Anzai A, Duque-Estrada B, et al. Consensus on the treatment of alopecia areata – Brazilian Society of Dermatology. *An Bras Dermatol*. 2020;95:39-52. doi:10.1016/j.abd.2020.05.006 **9** Bayramova A, Mane T, Hopkins C, et al. Photographing alopecia: How many pixels are needed for clinical evaluation? *J Digit Imaging*. 2020;33(6):1404-1409. doi:10.1007/s10278-020-00389-z **10** Mahmoudi H, Salehi M, Moghadas S, et al. Dermoscopic findings in 126 patients with alopecia areata: A cross-sectional study. *Int J Trichology*. 2018;10(3):118-123. doi:10.4103/ijt.ijt_102_17 **11** Tiwary AK, Mishra DK, Chaudhary SS. Comparative study of efficacy and safety of topical squaric acid dibutylester and diphenylcyclopropenone for the treatment of alopecia areata. *N Am J Med Sci*. 2016;8(6):237-242. doi:10.4103/1947-2714.185029 **12** Olsen EA, Hordinsky MK, Price VH, et al. Alopecia areata investigational assessment guidelines–Part II. *J Am Acad Dermatol*. 2004;51(3):440-447. doi:10.1016/j.jaad.2003.09.032 **13** Dhurat R, Saraogi P. Hair evaluation methods: Merits and demerits. *IJT*. 2009;1(2):108–119. doi:10.4103/0974-7753.58553 **14** Rossi A, Muscianese M, Piraccini BM, et al. Italian guidelines in diagnosis and treatment of alopecia areata. *G Ital Dermatol Venereol*. 2019;154(6):609-623. doi:10.23736/S0392-0488.19.06458-7 **15** Vidal CI. Overview of alopecia: a dermatopathologist's perspective. *Mo Med*. 2015;112(4):308-312. **16** Palo S, Biligi DS. Utility of horizontal and vertical sections of scalp biopsies in various forms of primary alopecias. *J Lab Physicians*. 2018;10(01):95-100. doi:10.4103/JLP.JLP_4_17 **17** Meah N, Wall D, York K, et al. The Alopecia Areata Consensus of Experts (ACE) study part II: Results of an international expert opinion on diagnosis and laboratory evaluation for alopecia areata. *J Am Acad Dermatol*. 2021;84(6):1594-1601. doi:10.1016/j.jaad.2020.09.028 **18** Lintzeri DA, Constantinou A, Hillmann K, et al. Alopecia areata – Current understanding and management. *J Dtsch Dermatol Ges*. 2022;20(1):59-90. doi:10.1111/ddg.14689 **19** Wyrwich KW, Winnette R, Bender R, et al. Validation of the Alopecia Areata Patient Priority Outcomes (AAPPO) questionnaire in adults and adolescents with alopecia areata. *Dermatol Ther (Heidelb)*. 2022;12(1):149-166. doi:10.1007/s13555-021-00648-z

DOP: February 2026 | EM-GBR-IAI-0038

©2026 Pfizer Ltd. All rights reserved