



Figure 1 A, Receding hairline and isolated hairs (known as *lonely* hairs). B, Total alopecia of the eyebrows, with preservation of the eyelashes. C, Hair loss on the arms. D, White patches, arborizing vessels, hairs of different diameters, and follicular hyperkeratosis.

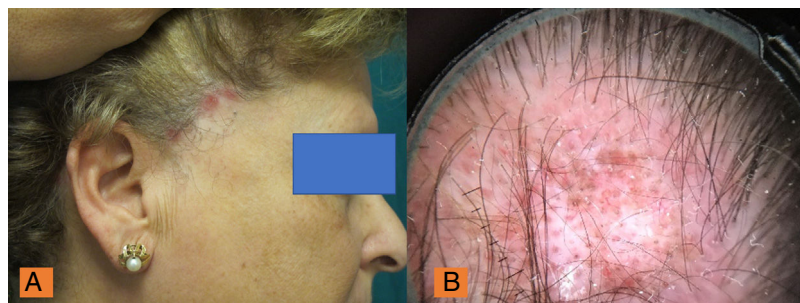


Figure 2 A, Atrophic plaques of alopecia with areas of erythema and inflammation in the temporal region. B, Red dots, white cicatricial patches, prominent branched capillaries (megacapillaries), and keratin plugs.

The simultaneous presence of frontal fibrosing alopecia (FFA) and DLE is an association rarely described in the literature. This association has been reported more frequently in women,¹ although cases have been occasionally reported in men.² FFA is a lymphocytic primary cicatricial alopecia of growing importance given its increasing prevalence in recent years, as reflected by the large number of articles published recently about its clinical presentation, diagnosis, and treatment. The most recent lines of investigation point to pathogenesis and pathophysiology related to application of certain hair products and sunscreens. We should also not forget the theories that point to a clear hormonal imbalance, more frequent in postmenopausal women, in the development of this disease. Recently, new diagnostic criteria have been proposed to facilitate identification of this condition. These are divided into major criteria (frontal or temporal cicatricial alopecia without keratotic papules on the body and diffuse and bilateral alopecia of the eyebrows) and other minor criteria (typical trichoscopy, occipital involvement, facial or body hair, and facial papules).³ Our patient pre-

sented with 2 major criteria and 2 minor ones. Likewise, severity scales have been validated⁴ and the trichoscopic features have been defined in large series of patients led by Spanish working groups.⁵

Although the association of FFA with other types of alopecia has been reported several times in the literature, no series have been published of cases that study the characteristics of these patients. An association has been reported with lichen planopilaris,⁶ androgenic alopecia,⁷ and DLE.^{1,2,8} Not all patients with both types of cicatricial alopecia (FFA and DLE) have a history of cutaneous lupus erythematosus.² Our patient was also taking enalapril among her medications. This drug has been linked to lichenoid eruptions⁹ and cutaneous lupus.¹⁰ We could not find any cases in the literature supporting a relationship with FFA.

In the context of cicatricial alopecia, DLE and FFA show subtle histologic differences based on presence or absence of mucin and differences in the characteristics of the lymphocytic infiltrate. In DLE, there is a greater lymphoplasmacytic predominance and presentation is usually at

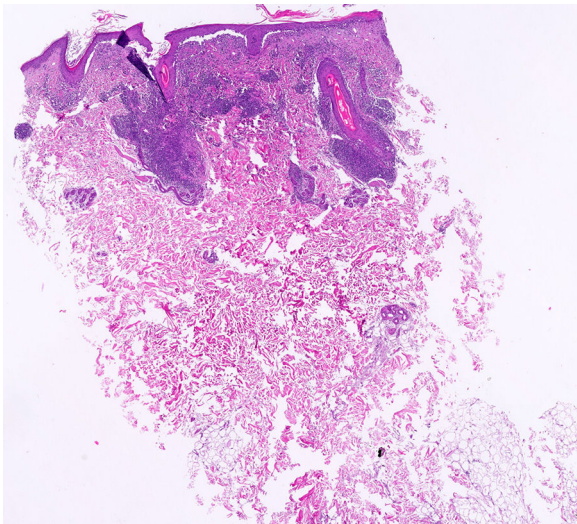


Figure 3 Hematoxylin and eosin stain $\times 2$, chronic inflammatory perifollicular and periadnexal infiltrate with vacuolar thickening and degeneration of the basal layer.

perifollicular, perivascular, and adnexal sites, whereas FFA is usually confined to perifollicular presentation.¹¹ However, it seems clear that concurrent presentation should point us to the presence of a common immunological pathway of the innate type that is responsible for the appearance of both processes in genetically predisposed individuals.

The use of hydroxychloroquine or chloroquine as monotherapy does not appear to be effective as therapy.⁸ We should proceed to joint treatment of both entities using topical/intralesional corticosteroids and the combination of antimalarial agents with 5- α -reductase inhibitors to ensure a more complete therapeutic coverage in these patients.¹²

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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