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TRICHOTILLOMANIA RESPONDED TO VILAZODONE

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ABSTRACT
Trichotilomania, better known as hair pulling disorder, is characterised by recurrent pulling out of one's hair, resulting in noticeable hair loss. It is associated with significant functional impairment and psychiatric comorbidity.Both pharmacotherapy and behaviour therapy have been tried in trichotillomania. We report a case that demonstrated complete remission after treatment with newer antidepressant drug, Vilazodone. This has not been previously reported.

KEYWORDS: Trichotillomania, Treatment, SSRIs, Vilazodone.

INTRODUCTION
Trichotillomania (TTM) or hair pulling disorder as per DSM-5 is characterised by recurrent pulling out of one's hair, resulting in noticeable hair loss along with repeated attempts to decrease or stop hair pulling.[1] In International Classification Disease -10th Edition (by WHO) , trichotillomania is classified as an impulse control disorder wherein the urge the pull out hair accompanied by an increasing sense of tension immediately before pulling out hair or attempting to resist and pleasure, gratification, or relief when pulling out the hair.[2] The locations and methods of pulling show great individual variation. Hair may be pulled from any region but is most commonly pulled, one hair at a time, from the scalp, lashes, and brows.[3]

TTM is associated with distress as well as social and occupational impairment. Due to deliberate hair pulling, the hair growth may be irreversibly damaged. Although the most notable consequence is hair loss, but recurrent pulling can also produce follicle damage, changes in the structure and appearance of regrown hair, scalp irritation, enamel erosion and gingivitis (from hair mouthing).[4] Swallowing of hair may lead to complications like gastrointestinal obstruction, trichobezoar, trichophytobezoar[5,6] and gastric perforation.[7] Less common medical complications include digit purpura, musculoskeletal injuries (carpal tunnel syndrome; back, shoulder and neck pain) and blepharitis.[1] TTM is also often accompanied by other comorbid psychiatric disorders e.g. major depressive disorder, excoriation (skin-picking) disorder[1,8], anxiety disorder and developmental problems.[6,9]
A number of biological hypotheses put forward to explain TTM include dysregulation of the serotonin and dopamine systems, endogenous opiate activity, significantly reduced left putamen and left ventricular volumes, increased right superior parietal activity, decreased activity of frontal-parietal and left caudate regions.[4] The environmental factors which act as triggering events include specific features of the hair, emotional experiences, particular settings, negative cognition about appearance, fear of being negatively evaluated, shame related cognitions, emotional states , boredom, frustration, loneliness etc.[1,4] Also, an association has been reported with specific settings such as studying, watching TV, driving, talking over phone.[8] Family history and cultural factors are also important.[10,11] The hair pulling behaviour is maintained either by positive or negative reinforcers.[4,12]

CASE REPORT
A 23 year old female of middle socioeconomic status referred by a dermatologist presented to psychiatry outpatient department with patchy hair loss over the scalp since one and a half years. The patient had an uncontrollable, irresistible, repetitive urge to pull out her scalp hair. It resulted in significant distress for being unable to control this habit. The hair-pulling behaviour had first appeared when she started her job. There was no identifiable significant stressors. The hair pulling had become particularly distressing and problematic over the past six months.The hair pulling spells occurred on a daily basis, mostly before sleeping, when she was alone in her room listening to the radio or watching television. She reported a feeling of mounting tension before the act of hair pulling, with an accompanied sensation of itching. The tension was alleviated when she pulled the hair out. She would pull out countless hairs over few hours. Later, she would secretly dispose of the plucked

out hair after packing them in a packet. There was no history of eating the hair. There was no history of loss of appetite, abdominal pain, diarrhoea or constipation.

There was a significant deterioration in her social functioning as she had started avoiding going out with her friends and attending social gatherings.

General physical and systemic examination, including central nervous system was normal. On local examination, a discrete patch of alopecia was seen over the scalp (Fig). There was no evidence of scaling or inflammation. Examination of the mucous membranes, nails, oral cavity and abdomen was normal. Mental status examination revealed an average built young lady with adequate grooming and normal psychomotor activity. Mood was reported as anxious. Thinking revealed preoccupation with the problem. There was no abnormality in perception and higher mental functions. The laboratory investigations, including haemoglobin, complete blood count, liver function tests, kidney function tests, thyroid function tests and blood sugar were normal. Her ultrasound (abdomen) and MRI brain were also normal.

She was diagnosed as suffering from hair pulling disorder or trichotillomania and started on a new antidepressant, Vilazodone, 20 mg daily after meals and tablet clonazepam 0.25 mg, if required. After 2 weeks, she reported mild improvement in her urge and the dose of Vilazodone was increased to 40 mg daily. On following her up after 6 weeks, she reported marked improvement and the urge to pull hair was only occasional.

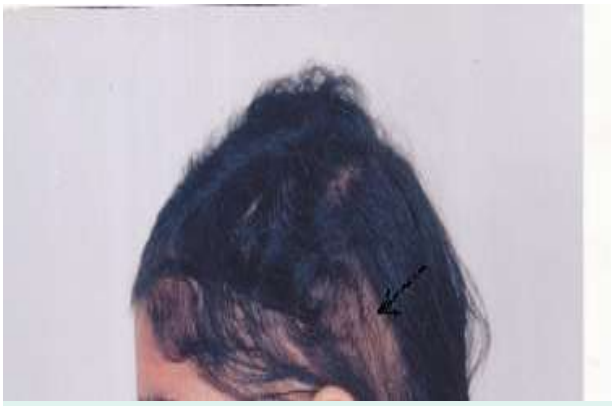

Figure: Showing bald patch due to hair pulling disorder

DISCUSSION

Both pharmacotherapy and Cognitive Behaviour Therapy (CBT) are used for treatment of TTM, although mono-therapy with either is likely to produce only partial symptom reduction.[4] CBT interventions include a variety of specific techniques like awareness training, self-monitoring, aversion, covert sensitization, negative practice, relaxation training, habit-reversal training, stimulus control, and overcorrection.[13,14] But the core psychotherapeutic interventions remain awareness training, stimulus control and competing response training.[15] The combination of psychological treatment with pharmacotherapy yields superior improvement.[15,16] In our case psychological treatment was not used.

A number of drugs including selective serotonin reuptake inhibitors (SSRIs e.g. fluoxetine, clomipramine) and serotonin-norepinephrine reuptake inhibitors (SNRIs, e.g., venlafaxine, duloxetine) have been used in TTM but with variable results.[17-20] The present case responded to Vilazodone, a new SSRI, 5-HT1A receptor partial agonist. This has not been yet reported in literature.

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