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Epidemiology of alopecia areata in Hispanic/Latinx patients

To the Editor: A recent study by Feaster and McMichael examined the epidemiology of alopecia areata (AA) in Black patients.[1] A similar unmet need exists to describe the characteristics of AA in Hispanic/Latinx (H/L) patients, the prevalent majority in California (39.4%, US Census Bureau 2021).

We retrospectively identified H/L patients diagnosed with AA (International Classification of Diseases [ICD] L63), including alopecia totalis (L63.0) and alopecia universalis (L63.1), at the University of California, Irvine (2015-2022) (IRB 2016-3076). Demographic characteristics were assessed by chart review, comorbid conditions by ICD codes, and clinical presentation by documented physical exams.

A total of 197 H/L patients with AA were included in this study (62.9% female; F:M, 1.7:1). Patient age at diagnosis ranged from 4 months to 76 years (mean 33 years). Overall, 135 patients (68.5%) were diagnosed with AA before age 40. The largest age group was 0 to 9 year-olds (19.8%) (Table I). Patients presented with patchy (n = 147, 79.2%), diffuse (n = 19, 12.9%), or ophiasis patterns (n = 3, 1.5%), with rare cases of alopecia totalis (n = 7, 3.6%) and alopecia universalis (n = 12, 6.1%). Only 12.2% (n = 24) had eyebrow, eyelash, or beard involvement, and 4% (n = 8) had body hair involvement.

The most common comorbidity in patients overall was atopy (n = 48, 24.4%), including allergic rhinitis (n = 24, 12.2%), asthma (n = 20, 10.2%), and/or atopic dermatitis (n = 13, 6.6%). Thirty-five patients (17.8%) had 1 or more coexisting autoimmune conditions, most commonly rheumatoid arthritis (n = 17, 8.6%), followed by thyroid disease (n = 11, 5.6%). No patients had celiac disease, myasthenia gravis, or inflammatory bowel disease. Eighty-five patients (43.1%) had another dermatologic condition.

Table I. Distribution of age at diagnosis and assigned sex at birth of Hispanic/Latinx patients with alopecia areata

Age (y)	Male, *n* (%)	Female, *n* (%)	Total, *n* (%)
0-9	14 (19.2)	24 (19.4)	38 (19.3)
10-19	19 (26.0)	15 (12.1)	34 (17.3)
20-29	13 (17.8)	20 (16.1)	33 (16.8)
30-39	15 (20.5)	15 (12.1)	30 (15.2)
40-49	8 (11)	22 (17.7)	30 (15.2)
50-59	3 (4.1)	18 (14.5)	21 (10.7)
60-69	1 (1.4)	5 (4)	6 (3.0)
70-79	—	5 (4)	5 (2.5)
Total	73 (37.1)	124 (62.9)	197 (100)
Mean age	29	36	33
SD	15	21	19

Table II. Medical comorbidities of Hispanic/Latinx patients with alopecia areata

Comorbidities	Male, *n* (%)	Female, *n* (%)	Total, *n* (%)
Seborrheic dermatitis	9 (12.3)	34 (27.4)	43 (21.8)
Vitamin D deficiency	13 (17.8)	30 (24.2)	43 (21.8)
Hyperlipidemia	13 (17.8)	26 (21)	39 (19.8)
Obesity	19 (26)	16 (12.9)	35 (17.8)
Gastroesophageal reflux disease	8 (11)	24 (19.4)	32 (16.2)
Sleep disorders	10 (13.7)	17 (13.7)	27 (13.7)
Depression	4 (5.5)	20 (16.1)	24 (12.2)
Allergic rhinitis	10 (13.7)	14 (11.3)	24 (12.2)
Anemia	4 (5.5)	20 (16.1)	24 (12.2)
Hypertension	4 (5.5)	17 (13.7)	21 (10.7)
Asthma	9 (12.3)	11 (8.9)	20 (10.2)
Rheumatoid arthritis	4 (5.5)	13 (10.5)	17 (8.6)
Telogen effluvium	2 (2.7)	13 (10.5)	15 (7.6)
Type II diabetes mellitus	2 (2.7)	12 (9.7)	14 (7.1)
Androgenetic alopecia	3 (4.1)	11 (8.9)	14 (7.1)
Anxiety	2 (2.7)	11 (8.9)	13 (6.6)
Atopic dermatitis	4 (5.5)	9 (7.3)	13 (6.6)
Thyroid disease	1 (1.4)	10 (8.1)	11 (5.6)
Psoriasis	1 (1.4)	8 (6.5)	9 (4.6)
Vitiligo	4 (5.5)	2 (1.6)	6 (3)
Iron deficiency	—	5 (4)	5 (2.5)
Irritable bowel syndrome	—	5 (4)	5 (2.5)
Systemic lupus erythematosus	—	3 (2.4)	3 (1.5)
Hidradenitis suppurativa	1 (1.4)	1 (0.806)	2 (1)
Multiple sclerosis	1 (1.4)	—	1 (0.508)
Type I diabetes mellitus	—	1 (0.806)	1 (0.508)

Seborrheic dermatitis was also common ($n = 43$, 21.8%) (Table II).

Other comorbidities included Vitamin D deficiency ($n = 43$, 21.8%), hyperlipidemia ($n = 39$, 19.8%), obesity ($n = 35$, 17.8%), gastroesophageal reflux disease ($n = 32$, 16.2%), and anemia ($n = 24$, 12.2%). Psychiatric comorbidities including depression, anxiety, or sleep disorders were identified in 14.2%, with absence of documented history of suicide attempts (Table II).

Our study shows that H/L patients with AA have a similar average age at diagnosis, slight female predominance, and increased atopy compared to the general population in recent AA studies.[1,2] Male H/L patients with AA were younger than female at diagnosis ($P = .01$, Table I). Interestingly, the most common autoimmune comorbidity in H/L was rheumatoid arthritis, compared to thyroid disease in Black patients[1] and overall patients with AA.[2,3] This finding may be a reflection of a larger trend, as rheumatoid arthritis in the H/L population has been on the rise.[4] Thyroid disease in our H/L cohort with AA was slightly higher than the 4.8% reported in the general Hispanic population.[5] Atopy and hypertension were less common in H/L than in Black patients[1] or patients with AA overall, but gastroesophageal reflux disease was more prevalent.[3]

A strength of our study is that most patients were evaluated by a hair specialist on the study team (NAM). Limitations include the small sample size, lack of a control group, and that patients may have received additional healthcare outside of our center. The study findings increase the current knowledge of the demographics of H/L patients with AA, and heighten awareness of associated inflammatory comorbidities, in particular rheumatoid arthritis.

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Conflicts of interest

None disclosed.

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Clinical and pathological features of cutaneous manifestations in VEXAS syndrome: A multicenter retrospective study of 59 cases

To the Editor: VEXAS (vacuoles, enzyme E1, X-linked, auto-inflammatory, somatic) syndrome is a late-onset autoinflammatory condition due to myeloid-restricted somatic mutations in the ubiquitin-activating enzyme 1 gene.[1] Skin involvement seems to be one of the most common symptoms,[1-4] and may be the first manifestation of VEXAS syndrome.[5] However, most studies have been performed in non-dermatology departments with no centralized review of cutaneous involvement and limited numbers of patients.[4,5]

In this multicenter nationwide retrospective study, all 59 patients from the French VEXAS study group (NFVS) database with photographs of skin lesions and/or skin biopsies available for centralized review on June 15, 2021, were included. This study received approval from our Institutional Review Board (CLEP Decision no.:AAA-2021-08040).