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COMMENTARY

Alopecia areata: Time for position statement to include new systemic therapeutic advances

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Over the decades, managing severe alopecia areata (AA) has proven to be frustrating for most dermatologists and patients. This frustration has been rooted for the past decades by the absence of effective systemic treatments.[1] However, times are changing, and recent advances in understanding the immune mechanisms of the disease have led to the development and approval of new systemic treatments, revolutionizing the approach to managing AA.[2]

While not life-threatening, the disease significantly impacts the quality of life and is often underestimated. Consequently, there is a high therapeutic demand. Recent randomized control trials have validated the efficacy of systemic JAK inhibitors (e.g. baricitinib and ritlecitinib) in treating moderate to severe AA. This marks a significant milestone in managing the disease, revisiting treatment goals to achieve a SALT score of less than 20.[3,4]

Before the approval of systemic JAK inhibitors, the treatment of AA with systemic agents was limited to the off-label use of systemic steroids and/or other immunomodulating agents (e.g. methotrexate and cyclosporine) with limited supporting data regarding their efficacy.

Now, recommendations must incorporate these new therapeutic options into their algorithms. A European group of experts has produced a consensus statement for using systemic agents in AA management.[5] The treatment algorithm prioritizes systemic JAK inhibitors as a first-line therapy for patients requiring a systemic agent, aligning with recent FDA and EMA approvals for moderate to severe AA. Other immunomodulating agents, such as cyclosporine, methotrexate or azathioprine, are considered as next lines in case of contraindications, failure, and/or side effects of systemic JAK inhibitors.

It is essential to note that systemic steroids can still be proposed in case of acute flare (lasting <6 months), with the aim of achieving rapid hair regrowth or in case of contraindication to other immune-modulating agents. Low-dose oral minoxidil could be added as an adjuvant therapy but should not be used in monotherapy.

The "wait and see" approach suggested by some authors, supported by spontaneous hair regrowth, should no longer be an option for patients eligible for systemic therapy. Recent RCT results indicate a low level of response in patients with moderate to severe disease included in the placebo group. To prevent the risk of relapse, this recommendation also suggests treating patients for at least 6–12 months after complete remission.

Children can also be treated with systemic therapies; ritlecitinib is currently the only JAK inhibitor approved for AA treatment in children from the age of 12. However, children below the age of 12 could also receive systemic therapies if indicated.

In conclusion, this expert statement comes at the right time and align with recent decisions regarding the approval of JAK inhibitors for the management of moderate to severe alopecia areata.

CONFLICT OF INTEREST STATEMENT

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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