

Quetiapine for the treatment of trichotillomania

Quetiapina para o tratamento de tricotilomania

Dear Editor,

Trichotillomania is a poorly understood disorder characterized by repetitive hair pulling that leads to noticeable hair loss, distress, and social or functional impairment. It is typically confined to one or two sites of the body. It most frequently affects the scalp but can also involve eyelashes, eyebrows, pubic hair, body hair, and facial hair.^{1,2}

In this report, we describe a case of a patient treated with the atypical antipsychotic quetiapine. SRB is a 20-year-old woman, who was diagnosed with trichotillomania. She had a history of 8 years of hair plucking before seeking treatment. On admission, she presented anxiety and depressive symptoms, but did not meet criteria for either anxiety or mood disorders. Hair pulling worsened when she was anxious, but also occurred in other situations, especially if she was unfocused. Routine physical examinations and investigations were all within normal limits, including liver enzymes, except for a bald patch covering approximately 25% of her back scalp. Although cognitive behavioral therapy (CBT) consistently shows positive results for the treatment of trichotillomania and it is available in our unit, she refused the

treatment, because it overlapped with work time. She was started on fluoxetine 20 mg per day, later titrated up to 40 mg per day. Hair pulling and anxiety symptoms improved, but activation side effects occurred, mainly insomnia and weight loss. After 4 weeks of fluoxetine 40 mg per day, quetiapine was introduced, beginning with 25 mg bedtime, titrated up to 100 mg in a week. Both fluoxetine activation side effects and hair pulling remitted in two weeks. Cessation of hair-plucking maintained, at the time of reporting, for a period of 4 months.

To date, studies on trichotillomania treatment using behavioral and pharmacological interventions, alone or in combination are equivocal with few showing a sustained cessation of hair-plucking. These studies suggest that the combination of pharmacological treatment and habit reversal therapy (HRT), a cognitive behavioral technique, may be more efficacious for the treatment of trichotillomania than either approach alone.³ Our report supports the need of further investigation of quetiapine, other atypical antipsychotic drugs, and their association with selective serotonin reuptake inhibitors in the treatment of trichotillomania,⁴ particularly if therapeutic gains would maintain after medication discontinuation, or if additional structured psychosocial intervention is required to yield long-term remission.⁵

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Note: USP = Universidade de São Paulo; ANJOTI = Associação Nacional do Jogo Patológico e Outros Transtornos do Impulso; FAPESP = Fundação de Amparo a Pesquisa de São Paulo.

For more information, see Instructions for authors.

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