



CLINICO-DERMOSCOPIC PROFILE OF ALOPECIA AREATA: A CROSS-SECTIONAL STUDY FROM WESTERN INDIA

Dr Devyani Sapra MD^{1*}, Nisha Verma MD², Dr Saurabh Mahajan MD³

^{1*}Command Hospital, Air Force Bangalore dvyniz@gmail.com

²Base Hospital, Delhi Cantt nisha.afmc@gmail.com

³Station Health Organisation, Shakurbasti saurabhmhjn@gmail.com

***Corresponding author:** Dr Devyani Sapra,
Command Hospital, Air Force Bangalore

Abstract

Background : Alopecia areata is a chronic, inflammatory, non-scarring hair disorder with variable clinical presentation and severity. Its diagnosis is primarily clinical, though dermoscopy (trichoscopy) has emerged as a non-invasive tool that aids in visualization of subsurface features and reduces the need of biopsy.

Aim and Objectives : To study the various dermoscopic findings in alopecia areata and correlate clinical severity and disease activity with dermoscopic findings.

Methodology : A hospital-based cross-sectional study was conducted among treatment naïve patients of alopecia areata. Severity of Alopecia Tool and SBN (scalp, body, nail) scale was used to assess the severity and grading of the disease. Hair pull test was used to assess the disease activity. Data were analysed using Statistical Package for the Social Sciences (SPSS) for Windows.

Results : The study population (n=60) comprised 38 (63.3%) males and 22 (36.7%) females, with a mean age of 25.2 ± 8.91 years (range: 7–46 years), and the most commonly affected age group being 21–30 years (51.7%). The mean disease duration was approximately 5 months, with 75% patients showing progressive disease, 15% having no progression, and spontaneous regrowth observed in 10%; most cases involved only the scalp (88.3%), with patchy alopecia being the predominant pattern (85.0%). Majority of patients had less severe disease (83.3%) based on SBN grading, and 46.7% demonstrated a positive hair pull test indicating active disease. A significant association was observed between disease severity and dermoscopic features such as yellow dots, black dots, and tapering hair ($p < 0.05$), while other features showed no significant correlation. Dermoscopic features including black dots, broken hair, tapering hair, and coudability hair were significantly associated with disease activity ($p < 0.05$), whereas other findings did not show a significant association.

Limitation : A large sample size is required to establish significant correlation between the less studied dermoscopic featured with disease activity and severity.

Conclusion : The study highlights classical as well as less common dermoscopic features of alopecia areata. Yellow dots, black dots, and tapering hairs correlated with disease severity, while black dots, broken hairs, tapering hairs, and coudability hairs were significantly associated with disease activity. Other features such as tulip hair and Pohl–Pinkus constrictions indicate ongoing inflammatory activity.

Introduction

Alopecia areata (AA) is a common, chronic, inflammatory disease that causes non-scarring hair loss.¹ The severity ranges from small patches of hair loss, which usually recover spontaneously, to complete

alopecia where the prognosis for hair growth is poor.¹ The onset is generally within the first three decades of life although it can start at any age. There is a high frequency of a family history of AA in affected persons, ranging from 10% up to 42% of cases.²

The most common presentation is well-circumscribed, smooth surface, round, or oval bald localized patches of hair loss on the scalp (alopecia focalis), however, other extensive forms like diffuse alopecia, ophiasis, ophiasis inversus, alopecia totalis (loss of all scalp hair), alopecia universalis (loss of all hair over body including eyelashes and eyebrows), also exist. A new subtype of AA is acute diffuse and total alopecia of the female scalp characterized by rapid progression of diffuse alopecia of the female scalp, marked female predominance and a favourable prognosis.³ Nail changes (diffuse fine pitting, longitudinal ridging, thin and brittle fingernails and toenails, and trachyonychia) may be seen in 3-30% of patients.⁴ Patients with nail problems usually exhibit the more severe forms of hair loss.^{5,6}

The diagnosis of AA is generally made based on history and clinical evaluation, based on typical pattern of hair loss. In the past, doubtful cases were confirmed by invasive procedures such as punch biopsy, which at times can be troublesome in patients. This problem has been overcome by dermoscopy, which magnifies subtle clinical surface features of skin lesions not normally visible even with a magnifying lens.

Dermoscopy is a non-invasive in-vivo technique and was used mainly for diagnosis of melanoma and monitoring of pigmented lesions.⁷ However it can be used in assessing other amelanotic skin lesions and hair disorders as well. Dermoscopy is performed with a hand-held instrument called a dermoscope. The procedure allows the visualization of subsurface skin structures in the epidermis, dermo-epidermal junction and upper dermis. Most commonly dermoscopes have a 10-fold magnification.

Dermoscopy of the hair, also called as trichoscopy is increasingly being used in all types of hair disorders as their dermoscopic features are almost diagnostic, which in turn alleviates the need of a skin biopsy in such conditions.

We conducted a detailed study correlating the clinical severity and activity with dermoscopic findings in alopecia areata among patients visiting Dermatology department of a tertiary care hospital in India.

Materials and methods

A hospital-based cross-sectional study was carried out at Dermatology department of a tertiary care hospital in western India during the period 01 May 2024 to 30 Sep 2025. All treatment naive patients with a clinical diagnosis of alopecia areata made by dermatologist were included in the study. Other causes of non-scarring alopecia such as female pattern hair loss, androgenetic alopecia, telogen effluvium, trichotillomania, and traction alopecia and cases of scarring or cicatricial alopecia were excluded from the study. Based on a prevalence^{8,9} of 0.57-3.8% of alopecia areata in various studies in the Indian population and from review of the online scientific databases, the sample size was calculated to be 52, hence a total of 60 patients were enrolled for the present study.

A thorough history, detailed clinical examination, and clinical photographs were taken for each patient. A pre-validated questionnaire was used to gather demographical data, history of the disease and etiological and risk factor history. Clinical and dermoscopic examination was done at every visit. Severity of Alopecia Tool (SALT) was used to assess the severity of the disease and SBN (Scalp, Body, Nail) scale for grading of AA.¹⁰ Disease activity in patients was objectively assessed by Hair Pull Test (HPT).

The data analysis was performed using SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp. Chi-square test was used to find association between different categorical variables. P-value <0.05 was taken as statistically significant. Pearson's correlation was used to determine correlation between two variables.

Results

The study population (n=60) comprised of 38 (63.3%) males and 22 (36.7%) females. Mean age of the study participants was 25.2 ± 8.91 (7 to 46 years). The most common age group affected was 21-

30 years (51.7%). Majority of the patients were from a salaried job background (43.3%) followed by students (28.3%) and housewives (23.3%).

Duration of the disease varied in the study population with mean duration of around 5 months (3 weeks to 18 months). Almost half of the patients with lesions had visited the OPD between 1 to 5 months of onset, while 22 patients (36.7%) reported disease duration of more than 5 months. A progressive course of disease was reported in around 75% patients, while 15% gave no history of progression in disease activity and spontaneous regrowth of hair was noted in almost 10% patients. Only 3 patients gave familial history of AA with either of the parents being affected. Positive history of atopy was present amongst the parents of 8 (13.3%) patients. Comorbidities such as Downs syndrome and thyroid disorder were noted in 06 patients, while 54 (90.0%) patients had no other associated diseases.

Alopecia areata of the scalp alone was noted in 53 (88.3%) of patients, while 7 (11.7%) patients had involvement of other body sites such as beard, eyebrows, moustache, and limbs in addition to scalp. Various clinical patterns of alopecia areata were observed in the patients under study. A total of 51 (85.0%) patients presented with patchy lesions, followed by reticulate pattern in 5 (8%), ophiasis in 3 (5%) and universalis pattern was observed in 1 patient (1.7%). Grading of patients done as per severity of the disease revealed maximum number of patients with less severe disease (50, 83.3%) as compared to others with higher severity in terms of involvement of extensive scalp, body and nails. Hair pull test (HPT) was performed on all the patients to ascertain the disease activity. Out of 60 patients of alopecia areata, 28 (46.7%) had a positive hair pull test while 32 (53.3%) had a negative hair pull test. Various trichoscopic findings found in our study are as shown in Figure 1, 2, 3 and tabulated in Table 1 as per the number of patients.

A significant association was seen between disease severity (SALT grading using SBN score) and dermoscopic features such as yellow dots, black dots and tapering hair ($p < 0.05$). No significant association of SBN score was seen with broken hair, short vellus hair, coudability hair, circle hair and spared white hair ($p > 0.05$). The findings are compiled in Table 2.

Association of dermoscopic features with disease activity by hair pull test are as shown in Table 3. Black dots, broken hair, tapering hair, and coudability hair were significantly associated with disease activity ($p < 0.05$) while yellow dots, short vellus hair, circle hair, spared white hair, tulip hair, and Pohl Pinkus hair were not found to have any correlation ($p > 0.05$).

Discussion

Alopecia areata (AA) is a common, clinically heterogeneous, nonscarring autoimmune hair loss.¹¹ Dermoscopy is a non-invasive and office based diagnostic tool has vastly improved the diagnosis of hair disorders including alopecia areata. We aimed to study the clinical and dermoscopic features of AA, and correlate clinical severity and disease activity of AA with the dermoscopic findings.

The most common age group affected by the disease as observed in the present study was 21-30 years with a mean age of 25 years. Hegde et al⁹ observed the most commonly affected age group as 15–30 years with a mean age of 23.58 years. In a study conducted by Bapu et al¹², the mean age of the patients with AA was 25.3 ± 19.7 years. Thus, the observations of the present study are concordant with the findings of other authors who observed the maximum number of cases in the second, third and fourth decades of life.

Male preponderance of 63.3% was observed in the present study with male to female ratio of 1.72:1. A male preponderance has been reported in the majority of the studies.^{13,14} Hegde et al⁹ observed that males were more commonly affected than females with a male: female ratio of 2.57:1.

In our study, almost 50% of patients reported to the dermatology outpatient department within 1 to 5 months of disease onset. In a similar study conducted by Hegde et al⁹ mean duration of the disease was 14 months. However studies by conducted by Mahmoudi, et al¹³ and Guttikonda et al¹⁵ noted an extreme variation in the duration of the disease ranging from 1 month to 20 years and 10 days to 8 years respectively. Better education status and easy access to hospital setup amongst our patient clientele may have contributed to early reporting of AA.

A total of 46 (76.7%) patients had a progressive course with definite increase in number or size of patches or the area of involvement. However, 8% of patients gave a history of spontaneous but incomplete regrowth at the time of presentation that warranted treatment. Mahmoudi, et al¹³ in their study reported that 37.3% had stable, 31.7% remitting, and 31% had progressive disease. However in Bapu et al¹² in their study, reported that 88.8% patients had progressive disease versus 11.2% who were non progressive. Previous studies have not emphasized on the course of disease as it is highly unpredictable, with spontaneous regrowth of hair occurring in 80% of patients within the first year, and sudden relapse at any given time.^{3,16} The presentation may thus have extreme variability not only at onset but also in the duration, extent, and pattern of hair loss during any subsequent episodes of active hair loss.^{17,18}

In our study, 6 (10%) patients had an associated underlying systemic disorder such as thyroid disease, Down's syndrome etc. A personal or family history of atopy was noted in 13% of patients in the present study. Similar associations were found in a study conducted by Guttikonda et al¹⁵ in 2016 where they found 8% patients with associated thyroid abnormalities and 32% (16/50) with atopy.

This study reported that scalp was the predominantly affected site in 59 patients (98.3%). One patient had full body involvement. Of these 59 patients, the disease was limited only to scalp in 88.3% (53/59) and the remaining showed involvement of other sites like beard, moustache, eyebrows, limbs etc along with scalp. Predominant involvement of the scalp was also seen in the studies by Guttikonda, et al¹⁵ (80%), Hegde, et al⁹ (73%). As in the present study, the above studies had noted smaller percentages of beard, moustache, eyebrow, eyelash, and limb involvement, and the universalis pattern of disease. Various clinical patterns of the disease were observed in our patients under study. Patchy alopecia was seen in 85% (patchy multiple 46.7% and patchy localized 38.3%), patients followed by reticulate (8.3%), ophiasis (5%) and universalis (1.7%) patterns. In the study by Bapu et al¹², patchy localized (65.5%), patchy multiple (22.4%), ophiasis pattern (4.3%) were the common clinical patterns noted, while in the study by Inui et al³, patchy multiple (38.3%), diffuse (19%), and totalis patterns (17%) comprised the majority of AA subtypes. The study by Guttikonda, et al¹⁵ and Mane et al⁴ also noted that patchy alopecia as the most common pattern involving 84% and 87.7% of patients respectively. Most of our patients had S1 (86.66%) followed by S2 (11.66%) and S5 (1.66%) grade of scalp severity; which were found to be in agreement with the findings in the study by Bapu et al¹² where they reported S1 (72.4%), S2 (10.3%), and S4 (10.3%) as the most common grades. Similar findings were noted by Hegde et al⁹ and Guttikonda et al¹⁵ in their studies with the preponderance of S1 (57.33% and 58% respectively) grade of severity.

A positive hair pull test was found in 28 out of 60 patients (46.7%) while the remaining 32 (53.3%) had a negative hair pull test. Similar findings have been seen in the earlier studies done in literature.^{12,13,15}

Common dermoscopic findings of AA reported in the literature such as yellow dots (YD), black dots (BD), broken hair (BH), tapering hair (TH), short vellus hairs (SVH) and circle hair (CH) were seen in varied numbers in our study patients (Table 1). Some of the less frequently known and newer dermoscopic findings such as coudability hair, Pohl Pinkus hair, tulip hair etc were also found in a few patients in our study.

The most commonly seen trichoscopic finding in our study was yellow dots seen in 76.7% patients. Both Mahmoudi et al¹³ and Bapu et al¹² in their studies reported YDs to be most common dermoscopic finding (82.5% and 89.6% respectively).

In our study, BDs were seen in 40% of cases. Inui et al³ also demonstrated BDs in 44.3% cases of AA. 48.4% patients studied by Mahmoudi et al¹³ had BDs, whereas Bapu et al¹² and Guttikonda et al¹⁵ reported 31% and 58% cases respectively with black dots on dermoscopy.

In our study, BHs were seen in 38.3% of the cases which was almost at par with the study findings of Hegde et al (37.33%). Inui et al³ also demonstrated BHs in 45.7% patients. Several other studies have reported varied incidence of BHs – Guttikonda et al¹⁵, 56%, Mane et al⁴, 55%, and Mahmoudi et al¹³, 9.5%, and Bapu et al¹² 12.9%. The above variations reflect variations in activity, severity, and duration of the disease.

We noted 30% patients had tapering hair which was consistent with the previous studies by Mahmoudi et al¹³ (30.95%), Guttikonda et al¹⁵ (26%) and Inui et al³ (31.7%). However Bapu et al¹² reported slightly lower incidences of TH (19.8%).

A study by Refu K in 2018 demonstrated tulip hair as one of the trichoscopic features in alopecia areata.¹⁹ We found this feature in one out of 60 patients of alopecia areata. Though this is not a routinely described finding but this can be taken as a marker of activity of the disease as this results due to fracture in the hair shaft.²⁰

In the present study, SVH was seen in 51.66% of the patients, similar to finding reported by Peter et al (57.14%) in their study.²¹ Though marginally higher values were noted by Mahmoudi et al (62.7%)¹³ and Hegde et al (68%)⁹. The difference in the findings could perhaps be due to previous treatment modalities undertaken by patients in these studies, whereas only treatment naïve patients were included in our study, excluding treatment bias.

Four out of 9 patients in our study who had circle hair on dermoscopy had clinically progressive disease and a positive hair pull test as compared to the remaining five who were either static or remitting in the disease course with a negative HPT. So, it is postulated that though they indicate disease remission, but may also represent residual disease activity in remitting phase or could have occur as a result of interplay of disease activity and remission in progressive phase of disease. However, further studies with a larger sample size are needed to substantiate the relevance of this finding.

In our study, we found coudability hair in 20% patients, which was comparable to the study by Guttikonda et al¹⁵ that reported an 14% incidence of coudability hair in AA patients.

Spared white hair were seen in 8% of our patients (5 out of 60). The incidence of this characteristic is not well established in the literature, but it has been postulated that sparing of white hair is a relative phenomenon; and white hairs, although less susceptible to the disease, are not immune to it. Ultrastructural evidence suggests that hair bulb melanocytes are specifically damaged in acute alopecia areata, even before the damage is morphologically detectable in hair bulb keratinocytes.²² Epitope spreading is likely to have a role in the broad nature of the anti-melanocyte response.

Pohl Pinkus Constrictions was seen in only two of our patients under study. Though PPC are not a very commonly stated feature, it has been observed in one patient in the study by Guttikonda et al, and in two patients in the study by Mane et al.

In our study, we found that yellow dots and black dots correlated positively with disease severity; in congruence with the previous studies. We also noticed a statistically significant association between of disease severity with tapering hair. Mahmoudi et al¹³ found that yellow dots related positively with severity of AA, however, vellus hairs, broken hairs, and exclamation mark hairs related negatively. In Bapu et al.'s study¹², yellow dots also had significant association with severity of AA. A positive correlation between black dots and yellow dots with AA severity and a negative correlation between vellus hair and AA severity was found in the study by Inui et al³.

In the present study, disease activity as assessed by hair pull test correlated positively with black dots, broken hair, tapering hair and coudability hair. Positive correlation has been observed earlier in the studies³ and the present study further confirms this fact. Lacarrubba et al²³ in their dermoscopic study of AA reported that exclamation mark hairs, and broken or cadaverized hairs were found most commonly in acute AA and their presence indicated progressive disease activity.

Strengths and limitations

The study encompasses a detailed description of the less commonly seen findings along with the well-known dermoscopic features of alopecia areata, such as Pohl-Pinkus constrictions, coudability hair etc. and it also includes the significance of these less-described dermoscopic features in terms of disease activity and severity. A large size population and sample size is required to establish a significant correlation between the less studied dermoscopic features with disease activity and severity.

Conclusion

The study covered holistically detailed description of less commonly seen findings. Most of the patients had scalp involvement in single or multiple patches. The disease course in more than three fourths of patients was progressive in the initial 6 to 8 months. Yellow dots, black dots and exclamation mark/ tapering hair on dermoscopy correlated positively with the severity of disease in the patients. Black dots, broken hair, exclamation mark/ tapering hair and coudability hair on dermoscopy were found to have a significant correlation with disease activity as assessed clinically with hair pull test. The other features seen on dermoscopy like tulip hair, Pohl-Pinkus constrictions hair, coudability hair etc signify the ongoing inflammatory disease process.

References

1. Griffiths C, Barker J, Bleiker T, G. CRJ, Creamer D, Rook A. In: Rook's Textbook of Dermatology. 9th ed. John Wiley & Sons Inc.; 2016. p. 89–89.
2. Madani S, Shapiro J. Alopecia areata update. *J Am Acad Dermatol*. 2000;42(4):549–66.
3. Inui S, Nakajima T, Itami S. Significance of dermoscopy in acute diffuse and total alopecia of the female scalp: review of twenty cases. *Dermatol Basel Switz*. 2008;217(4):333–6.
4. Mane M, Nath AK, Thappa DM. Utility of dermoscopy in alopecia areata. *Indian J Dermatol*. 2011 Jul;56(4):407–11.
5. Pratt CH, King LE, Messenger AG, Christiano AM, Sundberg JP. Alopecia areata. *Nat Rev Dis Primer*. 2017 Mar 16;3:17011.
6. Seetharam KA. Alopecia areata: an update. *Indian J Dermatol Venereol Leprol*. 2013 Oct;79(5):563–75.
7. Zalaudek I, Lallas A, Moscarella E, Longo C, Soyer HP, Argenziano G. The dermatologist's stethoscope-traditional and new applications of dermoscopy. *Dermatol Pract Concept*. 2013 Apr;3(2):67–71.
8. Hegde SP, Naveen KN, Athanikar SB, Reshme P. Clinical and dermatoscopic patterns of alopecia areata: a tertiary care centre experience. *Int J Trichology*. 2013 Jul;5(3):132–6.
9. Villasante Fricke AC, Miteva M. Epidemiology and burden of alopecia areata: a systematic review. *Clin Cosmet Investig Dermatol*. 2015;8:397–403.
10. Olsen EA, Hordinsky MK, Price VH, et al. Alopecia areata investigational assessment guidelines – Part II. National Alopecia Areata Foundation. *J Am Acad Dermatol* 2004;51:440–7.
11. Spano F, Donovan JC. Alopecia areata: Part 1: pathogenesis, diagnosis, and prognosis. *Can Fam Physician Med Fam Can*. 2015 Sep;61(9):751–5.
12. Bapu NG, Chandrashekar L, Munisamy M, Thappa DM, Mohanan S. Dermoscopic Findings of Alopecia Areata in Dark Skinned Individuals: An Analysis of 116 Cases. *Int J Trichology*. 2014;6(4):156–9.
13. Mahmoudi H, Salehi M, Moghadas S, Ghandi N, Teimourpour A, Daneshpazhooh M. Dermoscopic Findings in 126 Patients with Alopecia Areata: A Cross-Sectional Study. *Int J Trichology*. 2018;10(3):118–23.
14. Kaur S, Mahajan BB, Mahajan R. Comparative Evaluation of Intralesional Triamcinolone Acetonide Injection, Narrow Band Ultraviolet B, and their Combination in Alopecia Areata. *Int J Trichology*. 2015;7(4):148–55.
15. Guttikonda AS, Aruna C, Ramamurthy DVSB, Sridevi K, Alagappan SKL. Evaluation of Clinical Significance of Dermoscopy in Alopecia Areata. *Indian J Dermatol*. 2016;61(6):628–33.
16. Ito T. Recent advances in the pathogenesis of autoimmune hair loss disease alopecia areata. *Clin Dev Immunol*. 2013;2013:348546.
17. Mounsey AL, Reed SW. Diagnosing and treating hair loss. *Am Fam Physician*. 2009 Aug 15;80(4):356–62.
18. Finner AM. Alopecia areata: Clinical presentation, diagnosis, and unusual cases. *Dermatol Ther*. 2011;24(3):348–54.
19. Al-Refu K. Clinical Significance of Trichoscopy in Common Causes of Hair Loss in Children: Analysis of 134 Cases. *Int J Trichology*. 2018;10(4):154–61.

20. Ankad BS, Naidu MV, Beergouder SL, Sujana L. Trichoscopy in trichotillomania: a useful diagnostic tool. *Int J Trichology*. 2014 Oct;6(4):160–3.
21. Peter D, George L, Pulimood SA. Trichoscopic features of various types of alopecia areata in India: application of a hand-held dermoscope. *Australas J Dermatol*. 2013 Aug;54(3):198–200.
22. Pratt CH, King LE Jr, Messenger AG, Christiano AM, Sundberg JP. Alopecia areata. *Nat Rev Dis Primers* 2017;3:17011
23. Lacarrubba F, Dall'Oglio F, Rita Nasca M, Micali G. Videodermatoscopy enhances diagnostic capability in some forms of hair loss. *Am J Clin Dermatol*. 2004;5(3):205–8.

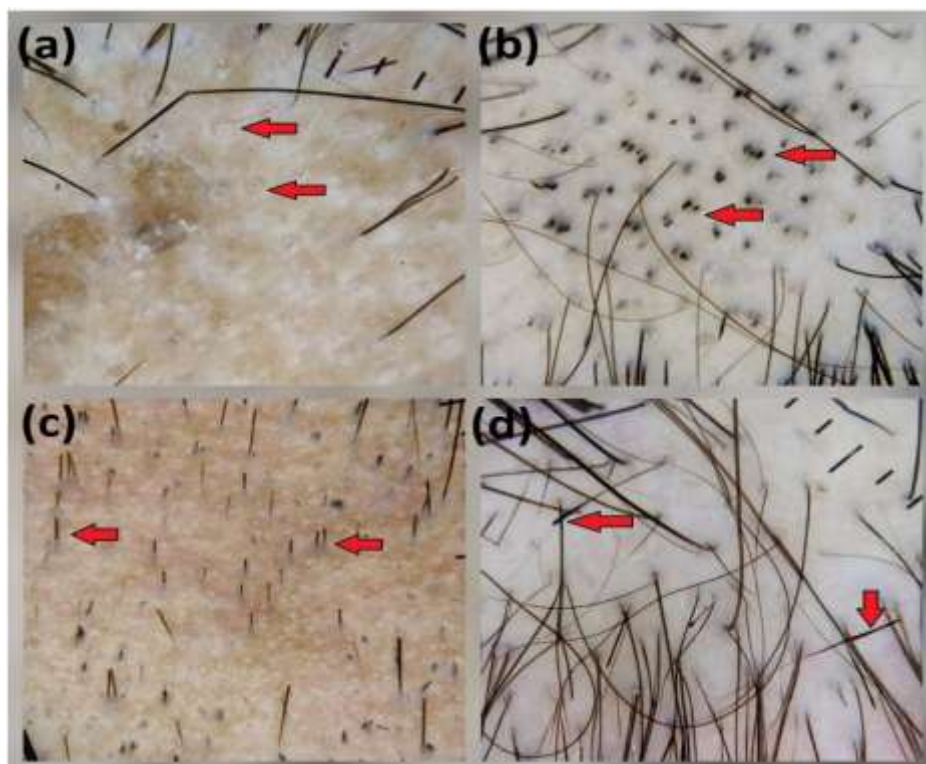


Fig 1: Trichoscopic features – (a) Yellow dots, (b) Black dots, (c) Broken hair, (d) Tapering hair

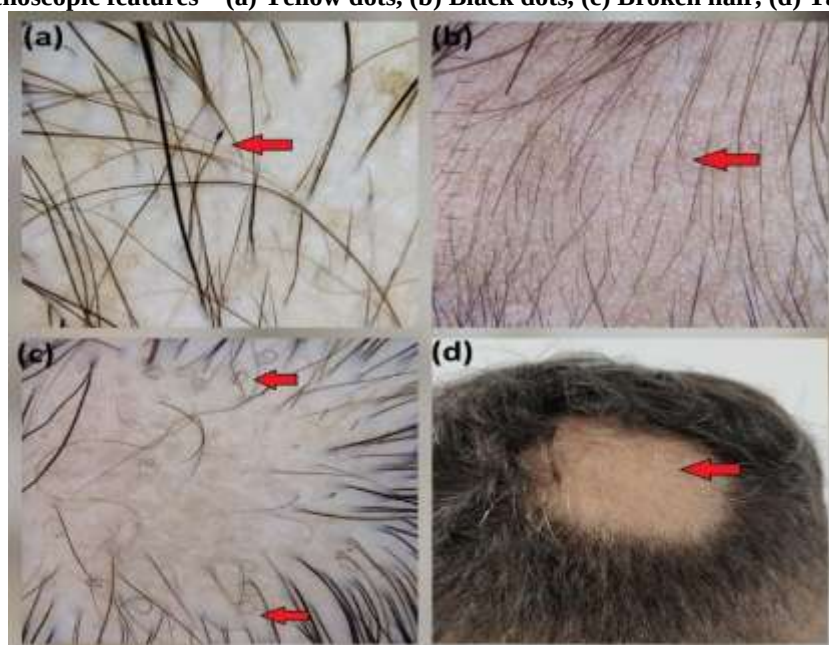


Fig 2 : Trichoscopic features – (a) Tulip hair, (b) Short vellus hair, (c) Circle hair (d) Sparing of white hair

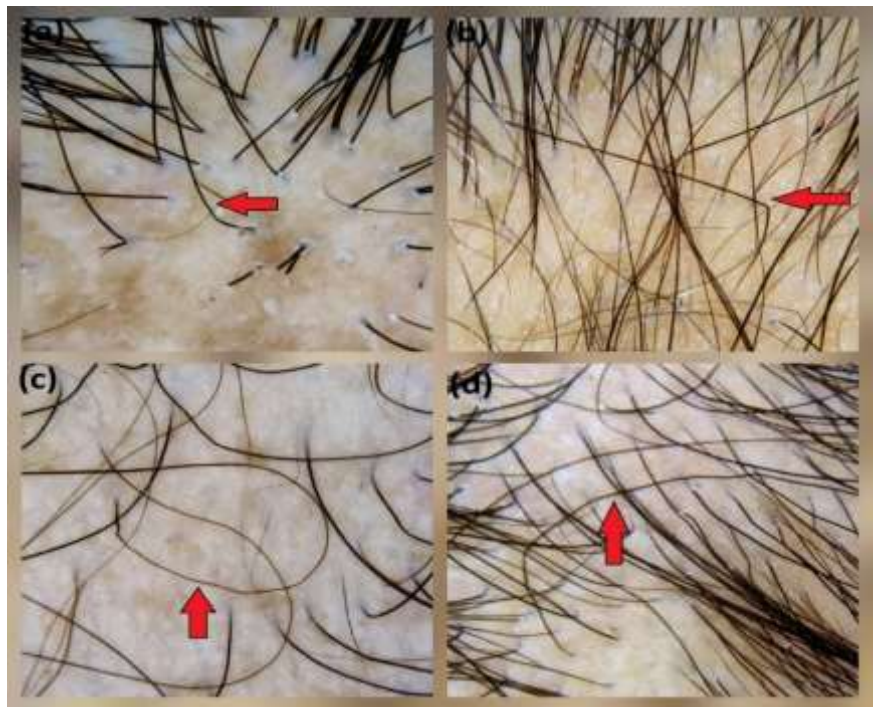


Fig 3 : Trichoscopic features – (a, b) Coudability hair, (c, d) Pohl pinkus hair

Trichoscopic Patterns	Number of patients		Total
	Seen	Not seen	
Yellow dots (YD)	46 (76.7%)	14 (23.3%)	60
Black dots (BD)	24 (40%)	36 (60%)	60
Broken hairs (BH)	23 (38.3%)	37 (61.7%)	60
Tapering hair (TH)	18 (30%)	42 (70%)	60
Short vellus hairs (SVH)	31 (51.66%)	29 (48.33%)	60
Coudability hair	12 (20%)	48 (80%)	60
Circle hair	9 (15%)	51 (85%)	60
Spared white hair (SWH)	5 (8.33%)	55 (91.7%)	60
Tulip hair	1 (1.66%)	59 (98.33%)	60
Pohl pinkus constriction	2 (3.33%)	58 (96.66%)	60

Table 1 : Various trichoscopic patterns seen among patients

Sev erity (SB N)	Nu mbe r of	Yellow Dots (YD)	Black Dots (BD)	Broken Hair (BH)	Tapering Hair (TH)	Short vellus hair (SVH)	Coudabilit y hair	Circle hair (CH)	Spared white hair (WH)

	pati ents	See n	Not see n	See n	Not see n	See n	Not see n	See n	Not see n	See n	Not see n	See n	Not see n	Se en	Not see n	Se en	Not see n
S1B 0N0	50	38 (76 %)	33 (66 %)	17 (34 %)	12 (24 %)	18 (36 %)	32 (64 %)	10 (20 %)	40 (80 %)	26 (52 %)	24 (48 %)	6 (12 %)	44 (88 %)	8 (16 %)	42 (84 %)	5 (10 %)	45 (90 %)
S1B 1N0	1	1 (10 0%)	1 (10 0%)	0 (0 %)	0 (0 %)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	1 (10 0%)	0 (0 %)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)
S1B 1N1	1	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)
S2B 0N0	3	2 (67 %)	0 (0 %)	3 (10 0%)	1 (33 %)	2 (67 %)	1 (33 %)	3 (10 0%)	0 (0 %)	2 (67 %)	1 (33 %)	2 (67 %)	1 (33 %)	1 (33 %)	2 (67 %)	0 (0 %)	3 (10 0%)
S2B 1N0	3	3 (10 0%)	0 (0 %)	3 (10 0%)	0 (0 %)	1 (33 %)	2 (67 %)	2 (67 %)	1 (33 %)	1 (33 %)	2 (67 %)	3 (10 0%)	0 (0 %)	0 (0 %)	3 (10 0%)	0 (0 %)	3 (10 0%)
S2B 1N1	1	1 (10 0%)	1 (10 0%)	0 (0 %)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	0 (0 %)	1 (10 0%)	1 (10 0%)	0 (0 %)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)
S5B 2N1	1	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)	0 (0 %)	1 (10 0%)
Tota l	60	46 (77 %)	36 (60 %)	24 (40 %)	14 (23 %)	23 (38 %)	37 (62 %)	18 (30 %)	42 (70 %)	31 (52 %)	29 (48 %)	18 (30 %)	42 (70 %)	9 (15 %)	51 (85 %)	5 (8 %)	55 (92 %)
p valu e		0.047		0.039		0.466		0.005		0.585		0.08		0.914		0.982	

Table 2 : Correlation of disease severity with various trichoscopic features

	Categories	Number of patients	Activity by Hair pull test		p value
			Negative(%)	Positive(%)	
Yellow dots (YD)	No	14	5 (15.6)	9 (32.1)	0.131
	Yes	46	27 (84.4)	19 (67.9)	
Black dots (BD)	No	36	28 (87.5)	8 (28.6)	<0.001
	Yes	24	4 (12.5)	20 (71.4)	
Broken hair (BH)	No	37	27 (84.4)	10 (35.7)	<0.001
	Yes	23	5 (15.6)	18 (64.3)	
Tapering hair (TH)	No	42	29 (90.6)	13 (46.4)	<0.001
	Yes	18	3 (9.4)	15 (53.6)	
Short vellus hair	No	29	15 (46.9)	14 (50)	0.809
	Yes	31	17 (53.1)	14 (50)	
Coudability Hair	No	48	30 (93.8)	18 (64.3)	0.004
	Yes	12	2 (6.2)	10 (35.7)	
Circle hair	No	51	28 (87.5)	23 (82.1)	0.562
	Yes	9	4 (12.5)	5 (17.9)	

Spared white hair	No	55	30 (93.8)	25 (89.3)	0.533
	Yes	5	2 (6.2)	3 (10.7)	
Tulip hair	No	59	32 (94.23)	27 (90.7)	0.832
	Yes	1	0 (00)	1 (3.4)	
Pohl-pinkus constriction	No	58	32 (94.7)	26 (87.2)	0.921
	Yes	2	0 (00)	2 (6.5)	

Table 3 : Correlation of various trichoscopic features with disease activity