CASE REPORT

Trichotillomania with trichorhizophagia in a schizophrenic patient: Case report and review of literature

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ABSTRACT

Trichotillomania is a disorder characterized by chronic hair pulling that often results in alopecia. Eating the part of hair pulled out is a common practice and trichorhizophagia is a new term to denote the habit of eating the root of hairs pulled out, associated with trichotillomania. Many psychiatric disorders are prevalent among patients with trichotillomania. Here we report a case of trichotillomania with trichorhizophagia in a 58-year-old man with schizophrenia. The various treatment options are also discussed.

Key words: Schizophrenia, trichorhizophagia, trichotillomania

INTRODUCTION

Trichotillomania is a disorder characterized by chronic hair pulling that often results in alopecia. Once believed to be rare, trichotillomania is now thought to affect as much as 4% of the population. Usually beginning in early childhood or adolescence, most patients with trichotillomania do not seek treatment until 17 years of age.[1] Patients with trichotillomania often hide their hair-pulling behavior, and the disorder is often suspected by typical dermatological findings, such as alopecia. Eating the part of hair pulled out is a common practice and trichorhizophagia is a new term to denote the habit of eating the root of hairs pulled out, associated with trichotillomania.[2] Comorbidity of trichotillomania with different psychiatric disorders is common. However, until recently there have been only few reports of trichotillomania in schizophrenia.[3,4] Here we report a case of trichotillomania with trichorhizophagia in schizophrenia and discussed the various treatment options.

CASE REPORT

A 58-year-old, married, Hindu, unemployed male, a
confirmed case of schizophrenia of 30 years duration with no family or past history of psychiatric illness, no history of any medical or surgical illnesses, presented in our OPD with pulling hair and eating the hair root for the last 5 years. There were no positive symptoms but had predominant negative symptoms. Prior to the consultation in our hospital, he was on irregular treatment with haloperidol. He used to pluck hair from the scalp and eyebrows and developed patches of hair loss in these areas. Usually he plucks one or two hairs at a time and plays with hair for some time or rubs the root of the hair along the lips and then discards it. At times he bites the hair and swallows the bitten part containing the root of hair discarding the rest. The patient admitted hair-pulling behavior and reported a kind of pleasure in doing this activity. He has not attempted to resist this habit and it was not a concern for him. There were patches of alopecia on the scalp and right eyebrows with no local inflammation, itching, or pain. The patient’s symptoms qualified for a diagnosis of trichorhizophagia.

As an outpatient, he was started on olanzapine and the dose was titrated to a maximum dose of 20 mg per day over
a period of 1 month. He showed significant improvement of schizophrenic symptoms except hair pulling behavior. Since behavior therapy was not possible at this stage as the patient was not cooperative, escitalopram 10 mg was added to the previous regime for controlling the hair pulling behavior. After 3 months of combined therapy he almost completely stopped the hair pulling behavior, subsequent biting, and eating hair roots without any exacerbation of psychotic symptoms. There was regrowth of scalp hair as well. Till date, the patient is maintaining improvement and is attending our OPD with regular follow up.

**DISCUSSION**

Trichotillomania is considered to be a rare disorder encountered in clinical practice. Although trichotillomania was reported to occur with many psychiatric disorders, the exact prevalence rate was not reported. Other comorbid conditions reported include dissociative experiences, dementia, Parkinson’s disease, partial seizures, and Prader-Willi syndrome. Possible hypothesized causes include a biological basis, as well as hair pulling in response to life stresses.

Current treatment strategies involve a multimodal approach. Some of the SSRIs especially escitalopram, fluoxetine, and fluvoxamine are found to be effective. Antipsychotics like haloperidol were also suggested. In some cases, a combination of SSRI with a typical antipsychotic may be warranted. Recently, there was a report of resistant trichotillomania treated with risperidone augmented with fluvoxamine. This combination worked well without any exacerbation of psychotic symptoms. The index case had compulsive plucking of hair and eating the hair root for the last 5 years, which was not part of any delusions or hallucinations. Although olanzapine has shown efficacy as monotherapy against psychosis, addition of escitalopram only produced marked improvement in compulsive behavior. Escitalopram was shown to be effective in many of the obsessive spectrum disorders. This case points to the efficacy of combination of olanzapine and escitalopram particularly in patients showing psychotic symptoms along with trichotillomania. Moreover, in patients with hair pulling behavior, it is prudent to inquire about trichophagy because it can lead on to rare but potentially life-threatening condition called trichobezoar.

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