GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester EUR Policy Statement on:

Hair Replacement Technologies

GM Ref: GM069

Version: 2.2 (25 January 2019)

Commissioning Statement

Hair Replacement Technologies	
Policy Exclusions **(Alternative commissioning arrangements apply)**	Hair loss (other than male pattern baldness which is considered to be a normal variant) should be investigated and any underlying cause treated as clinically appropriate. NHS wigs supplied as part of an agreed clinical pathway (for example, cancer is excluded from this policy). Treatment/procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).
Policy Inclusion Criteria	There are no mandatory criteria as hair replacement systems are considered to be aesthetic treatments and are not routinely commissioned. These technologies are not commissioned for failure of hair to re-grow following the end of a course of treatment that caused the initial loss. The NHS does make wigs available in certain circumstances. The current eligibility criteria (at the time of writing this policy) can be viewed at: NHS in England: help with health costs: Wig and Fabric Supports **Funding Mechanism** Individual funding request (exceptional case) approval: Requests must be submitted with all relevant supporting evidence.
Clinical Exceptionality	Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is: • Significantly different to the general population of patients with the condition in question. ***and as a result of that difference*** • They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.
Best Practice Guidelines	All providers are expected to follow best practice guidelines (where available) in the management of these conditions.

Contents

Policy Statement

Greater Manchester Health and Care Commissioning (GMHCC) Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission treatments/procedures in accordance with the criteria outlined in this document.

In creating this policy GMHCC/GM EUR Steering Group have reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

Equality & Equity Statement

GMHCC/CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. GMHCC/CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, GMHCC/CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMHCC EUR Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMHCC evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Joint Commissioning Board (GMJCB) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the GM EUR Operational Policy.

Aims and Objectives

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.

- ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.
- promoting the cost-effective use of healthcare resources.

Rationale behind the policy statement

Hair replacement technologies are considered to be aesthetic treatments and are not routinely commissioned. The efficacy of treatments for hair replacement is not clear as the evidence base is poor and the potential side effects of many interventions are not justified to manage an essentially aesthetic condition.

Treatment / Procedure

Male-pattern baldness is the most common type of hair loss. As well as affecting men, it can sometimes affect women (female-pattern baldness). It can be particularly difficult for both men and women to cope with.

Causes of Hair Loss

Androgenic alopecia (male and female-pattern baldness)

- Most common cause of hair loss
- Localised and systemic hair loss, which usually begins with the frontoparietal scalp and then the vertex
- Male-pattern baldness in females is indicative of androgen excess and may be accompanied by hirsutism in mild cases and virilisation in more serious ones
- Female-pattern baldness is similar but more diffuse, usually without complete baldness and maintaining the frontal hairline

Male-pattern baldness follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples. During female-pattern baldness, hair usually only thins on top of the head.

Male and female-pattern baldness is also called androgenic or androgenetic alopecia. Male-pattern baldness is a condition that runs in families, but it is not clear if this is the case with female-pattern baldness.

Alopecia areata

- Second most common presentation of non-scarring alopecia
- Hair is rapidly lost in circular or oval patches or, less commonly, may be diffuse involving the scalp
- May include facial or body hair
- May be episodic or persistent

Telogen effluvium

- Diffuse alopecia following a triggering event, such as surgery, childbirth, emotional stress, hormonal fluctuations, or medication use
- Hair loss occurs approximately 3 months after the event
- Usually affects less than 50% of the scalp
- Recovery is often complete once triggering factor is resolved

Anagen effluvium

- Diffuse hair loss that occurs as a result of exposure to certain toxins including some therapies and medications (e.g. Chemotherapy)
- Following toxic exposure, hair growth is abruptly interrupted and anagen hair is shed after 1 to 4 weeks
- Rapidly affects 80% to 90% of the scalp
- Complete recovery can be expected once the triggering factor is removed however, occasionally, the hair will fail to grow back or will have a different appearance following regrowth

Traction alopecia

- Hair loss that is caused by direct insult to hair
- Associated with such styling techniques as using hot rollers or braiding
- Pattern of hair loss may relate directly to technique used
- More common in black patients
- If continued, may progress to scarring alopecia

Trichotillomania (subtype of traction alopecia)

- Self-inflicted loss of hair, typically from frontoparietal region progressing backwards
- Regrowth of up to 1.5 cm may also be visible before hair is long enough to pull again

Cicatricial alopecia (or scarring alopecia)

- Hair loss that occurs with permanent destruction of hair follicles
- Often presents with inflammation arising from injury or disease
- Scalp lesions may also be present
- Initially localised, it may become diffuse in chronic presentations
- Scalp will gradually scar, becoming smooth without any evidence of hair follicles
- Once scarring is initiated, hair loss is permanent

Tinea capitis

- Fungal infection that causes hairs to break off close to the scalp leaving a 'black dot' effect
- Often a result of a secondary bacterial infection
- Scalp is intensely pruritic or painful
- Predominantly affects children; more commonly, inner city black populations

Alopecia neoplastica

- Hard nodules/tumors or flat unchanged skin with loss of hair
- Can be secondary to primary skin cancer of scalp or metastatic tumor

Alopecia mucinosa

- A form of localised hair loss sometimes seen in patients with mycosis fungoides, but may occur alone

Hair Replacement Therapies

Tattooing: For many people, it is possible to replicate hair with a tattoo. This is known as dermatography and generally produces good long-term results, although it is usually expensive and can only be used to replicate very short hair. This is usually carried out for eyebrows over a few hourly sessions and can even be used as a treatment for scalp hair loss caused by male-pattern baldness.

Wigs: Wigs can be a useful treatment for people with extensive hair loss.

Synthetic wigs: The cheapest wigs are made from acrylic and can cost anywhere between £60 and £200. As of April 2012, an NHS stock acrylic wig costs £63.35.

Acrylic wigs last for six to nine months. They are easier to look after than wigs made of real hair because they do not need styling. However, acrylic wigs can be itchy and hot, and need to be replaced more often than wigs made from real hair.

Real hair wigs: Some people prefer the look and feel of wigs made from real hair even though they are more expensive, costing anywhere between £200 and £2,000. As of April 2012, an NHS partial human hair wig costs £167.85 and an NHS full human hair wig made to order costs £245.40.

Real hair wigs last for three to four years, but are harder to maintain than synthetic wigs because they may need to be set and styled by a hairdresser and professionally cleaned.

A human hair wig is only available on the NHS if you are allergic to acrylic, or if you have a skin condition made worse by acrylic.

Hair weaves (or similar systems e.g. Interlace system): This can be used in moderate to severe hair loss or thinning. It is constructed from a breathable mesh and integrated into the existing hair, the hair is managed as normal but requires maintenance visits on a regular basis (the number per year depends on the system used). It can be removed if hair growth is restored.

Complementary therapy: Aromatherapy, acupuncture and massage are often used for alopecia, but there is not enough evidence to support their use as effective treatments.

Hair loss surgery: Most men and women considering hair loss surgery have male-pattern or female-pattern baldness. However, surgery is sometimes suitable for a range of alopecia conditions. Surgery for hair loss should only be considered after trying less invasive treatments, and it's not usually available on the NHS. The main types of hair loss surgery are explained below.

Hair transplant: Under local anaesthetic a small piece of scalp (about 1cm wide and 30-35cm long) is removed from an area where there is plenty of hair. The piece of scalp is divided into single hairs or tiny groups of hairs, which are then grafted onto areas where there is no hair.

Stitches are not needed to attach the grafts because they are held in place by the clotting (thickening) action of the blood when the hairs are inserted. Fine hairs are placed at the front of the scalp and thicker hairs towards the back in a process called grading. This helps achieve a more natural result. Within six months, the hair should settle and start to regrow.

Hair transplants are carried out over a number of sessions. There should be a break of nine to 12 months between procedures. As with any type of surgery, there is a risk of infection and bleeding, which can lead to hair loss and noticeable scarring.

Hair transplantation is not provided by the NHS. It can be expensive and take a long time.

Scalp reduction: Scalp reduction involves removing pieces of bald scalp from the crown and the top of the head to move hairy parts of the scalp closer together. This can be done by cutting out loose skin and stitching the scalp back together, or it can be done by tissue expansion.

Tissue expansion is where a balloon is placed underneath the scalp and inflated over several weeks to expand the skin in stages. The balloon is then removed and the excess skin is cut out.

Scalp reductions are not suitable for hair loss at the front of the scalp because it can cause scarring. There is also the risk of infection in the area.

Scalp reduction is not usually used for male-pattern baldness, but it is available on the NHS to people with scarring alopecia. Surgery should only be carried out after any underlying conditions have cleared up.

Artificial hair: Artificial hair implantation is marketed as a treatment for male-pattern baldness. It involves implanting synthetic fibres into the scalp under local anaesthetic. The technique is not available on the NHS.

Artificial hair implantation carries serious risks of infection and scarring, but clinics may be reluctant to inform people of the possible complications to avoid losing potential clients. Artificial hair implantation is not recommended by dermatologists due to the risk of complications such as:

- infection
- scarring
- synthetic fibres falling out

People considering hair loss surgery should explore more established treatments, such as hair transplantation and scalp reduction, because the advantages and disadvantages of these techniques are better understood.

Cloning: The latest research into hair loss treatments is studying hair cell cloning. The technique involves taking small amounts of a person's remaining hair cells, multiplying them, and injecting them into bald areas.

Cloning is intended to treat both male and female-pattern baldness. However, the science behind the technique is new and more trials are needed before it can be fully assessed.

Source = NHS choices

Epidemiology and Need

Male-pattern baldness is more common than female-pattern baldness, affecting around half of all men by 50 years of age. Female-pattern baldness becomes more common in women after the menopause (when a woman's periods stop at around age 52). Alopecia Areata can occur at any age, although it is more common in people aged 15-29. It affects one or two people in every 1,000 in the UK. Scarring alopecia occurs in both males and females, but is less common in children than adults. It accounts for about 7% of hair loss cases. Anagen Effluvium affects most people who have chemotherapy to some degree.

Source=NHS choices

Adherence to NICE Guidance

There is no NICE guidance available at the time of developing this policy.

There is no guidance produced by a NICE accredited process available.

Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

Date of Review

Three years from the date of the last review, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

Term	Meaning
Alopecia areata	Alopecia areata is an autoimmune condition. The immune system is the body's natural defence system, which helps protect it from infection by bacteria and viruses. Usually, the immune system attacks the cause of an infection, but in the case of alopecia areata it damages the hair follicles instead. It is not clear exactly why this happens. Fortunately, the hair follicles are not permanently damaged and in many cases the hair grows back within a few months.
Alopecia mucinosa	A form of localized hair loss sometimes seen in patients with mycosis fungoides, but may occur alone
Alopecia neoplastica	Hard nodules/tumors or flat unchanged skin with loss of hair. Can be secondary to primary skin cancer of scalp or metastatic tumor.
Anagen effluvium	Anagen effluvium is usually caused by medical treatments for cancer, most commonly chemotherapy. However, not all chemotherapy drugs cause hair loss and sometimes the hair loss is so small it is hardly noticeable. In some cases, other cancer treatments – including immunotherapy and radiotherapy – may also cause hair loss.
Androgenic alopecia (Male and female-pattern baldness)	Male-pattern baldness is hereditary, which means it runs in families. It is not clear if this is the case with female-pattern baldness. It is thought to be caused by oversensitive hair follicles (holes in the skin that contain the roots of each hair). This is linked to the hormone dihydrotestosterone (DHT), which is made from the male hormone testosterone. If there is too much DHT, the follicles react to it. The hair becomes thinner and grows for a shorter length of time than normal. The balding process is gradual because different follicles are affected at different times. The causes of female-pattern baldness are less well understood. Women who have been through the menopause may have an increased chance of female-pattern baldness because they have fewer female hormones.
Cicatricial alopecia (or scarring alopecia)	Scarring alopecia is caused by permanent damage to the hair follicles. In many cases, it is not clear why this happens, although it is sometimes the result of another condition. Conditions that can cause scarring alopecia include: • **scleroderma** – a condition that affects the body's connective (supporting) tissues, resulting in hard, puffy and itchy skin • **lichen planus** – a non-infectious, itchy rash that can affect many areas of the body

	• **discoid lupus** – a mild form of lupus that affects the skin, causing scaly marks and hair loss • **folliculitis decalvans** – a rare form of alopecia that most commonly affects men, causing baldness and scarring of the affected areas • **frontal fibrosing alopecia** – a type of alopecia that affects post-menopausal women where the hair follicles are damaged, and the hair falls out and is unable to grow back
Telogen effluvium	Telogen effluvium is a type of temporary hair loss that can be caused by your body reacting to: • hormonal changes, such as those that take place when a woman is pregnant • intense emotional stress • intense physical stress, such as childbirth • a short-term illness, such as a severe infection or an operation • a long-term illness, such as cancer or liver disease • changes in your diet, such as crash dieting • some medications, such as anticoagulants (medicines that reduce the ability of your blood to clot) or beta-blockers (used to treat a number of conditions, such as high blood pressure)
Tinea capitis	• Fungal infection that causes hairs to break off close to the scalp leaving a 'black dot' effect • Often a result of a secondary bacterial infection • Scalp is intensely pruritic or painful • Predominantly affects children; more commonly, inner city populations
Traction alopecia	• Hair loss that is caused by direct insult to hair • Associated with such styling techniques as using hot rollers or braiding • Pattern of hair loss may relate directly to technique used • More common in black patients • If continued, may progress to scarring alopecia
Trichotillomania (subtype of traction alopecia)	Self-inflicted loss of hair, typically from frontoparietal region progressing backwards.

References

1. GM EUR Operational Policy

Governance Approvals

Name	Date Approved
Greater Manchester Effective Use of Resources Steering Group	19/11/2014
Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning	May 2015
Greater Manchester Association Governing Group	02/06/2015
Bolton Clinical Commissioning Group	26/06/2015

Bury Clinical Commissioning Group	01/07/2015
Heywood, Middleton & Rochdale Clinical Commissioning Group	17/07/2015
Manchester Clinical Commissioning Group	North: 08/07/2015 Central: 30/07/2015 South: 24/06/2015
Oldham Clinical Commissioning Group	02/06/2015
Salford Clinical Commissioning Group	02/06/2015
Stockport Clinical Commissioning Group	24/06/2015
Tameside & Glossop Clinical Commissioning Group	22/07/2015
Trafford Clinical Commissioning Group	21/07/2015
Wigan Borough Clinical Commissioning Group	30/06/2015

Appendix 1 – Evidence Review

Hair Replacement Technologies
GM069

Search Strategy

The following databases are routinely searched: NICE Clinical Guidance and full website search; NHS Evidence and NICE CKS; SIGN; Cochrane; York; and the relevant Royal College and any other relevant bespoke sites. A Medline / Open Athens search is undertaken where indicated and a general google search for key terms may also be undertaken. The results from these and any other sources are included in the table below. If nothing is found on a particular website it will not appear in the table below:

Database	Result
Cochrane	Interventions for female pattern hair loss, Van Zuuren EJ, Fedorowicz Z, Carter B, Andriolo RB, Schoones J *Cochrane Database of Systematic Reviews* 2012, Issue 5
BMJ Best Practice	Androgenic Alopecia guidance (website)
General Search (Google)	Treatment provider websites
	NHS Choices web based information leaflet
Medline / Open Athens	Many case series and other studies of individual therapies. No metanalyses or commissioning guidelines found
Other	Guidelines for the Management of Alopecia Areata, S.P. MacDonald Hull, M.L. Wood, P.E. Hutchinson, M. Sladden, A.G. Messenger, 2003 British Association of Dermatologists, British Journal of Dermatology, 149, 692–699

Summary of the evidence

Most evidence related to the investigation and management of underlying conditions rather than hair replacement and so were outside of the remit of this policy. Treatment guidance was available for androgenic alopecia and for Alopecia Areata. The efficacy of treatments is not clear as the evidence base is poor and the potential side effects of many interventions are not justified to manage an essentially aesthetic condition.

The use of camouflage and tattooing for facial hair loss and of wigs for female where desired by the individual are the most commonly recommended treatments

Hair replacement systems are purely aesthetic therapies.

The evidence

Levels of evidence	
Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials
Level 3	Case-control or cohort studies

Level 4	Non-analytic studies e.g. case reports, case series
Level 5	Expert opinion

1. LEVEL 1: INTERVENTION REVIEW

Interventions for female pattern hair loss, Van Zuuren EJ, Fedorowicz Z, Carter B, Andriolo RB, Schoones J.. *Cochrane Database of Systematic Reviews* 2012, Issue 5

Abstract

Background: Female pattern hair loss, or androgenic alopecia, is the most common type of hair loss affecting women. It is characterised by progressive shortening of the duration of the growth phase of the hair with successive hair cycles, and progressive follicular miniaturisation with conversion of terminal to vellus hair follicles (terminal hairs are thicker and longer, while vellus hairs are soft, fine, and short). The frontal hair line may or may not be preserved. Hair loss can have a serious psychological impact on people.

Objectives: To determine the effectiveness and safety of the available options for the treatment of female pattern hair loss in women.

Search methods: We searched the following databases up to October 2011: the Cochrane Skin Group Specialised Register, CENTRAL in *The Cochrane Library* (2011, Issue 4), MEDLINE (from 1946), EMBASE (from 1974), PsycINFO (from 1806), AMED (from 1985), LILACS (from 1982), PubMed (from 1947), Web of Science (from 1945), and reference lists of articles. We also searched several online trials registries for ongoing trials.

Selection criteria: Randomised controlled trials that assessed the effectiveness of interventions for female pattern hair loss in women.

Data collection and analysis: Two review authors independently assessed trial quality and extracted data.

Main results: Twenty two trials, comprising 2349 participants, were included. A wide range of interventions were evaluated, with 10 studies investigating the different concentrations of minoxidil. Pooled data from 4 studies indicated that a greater proportion of participants (121/ 488) treated with minoxidil reported a moderate increase in their hair regrowth when compared with placebo (64/476) (risk ratio (RR) = 1.86, 95% confidence interval (CI) 1.42 to 2.43). In 7 studies, there was an important increase of 13.28 in total hair count per cm² in the minoxidil group compared to the placebo group (95% CI 10.89 to 15.68). There was no difference in the number of adverse events

Interventions for: In the twice daily minoxidil and placebo intervention groups, with the exception of a reported increase of adverse events (additional hair growth on areas other than the scalp) with minoxidil (5%) twice daily. Most of the other comparisons consisted of single studies. These were assessed as high risk of bias: They did not address our prespecified outcomes and provided limited evidence of either the efficacy or safety of these interventions.

Authors' conclusions: Although more than half of the included studies were assessed as being at high risk of bias, and the rest at unclear, there was evidence to support the effectiveness and safety of topical minoxidil in the treatment of female pattern hair loss. Further direct comparison studies of minoxidil 5% applied once a day, which could improve adherence when compared to minoxidil 2% twice daily, are still required. Consideration should also be given to conducting additional well-designed, adequately-powered randomised controlled trials investigating several of the other treatment

2. LEVEL N/A: TREATMENT GUIDANCE

BMJ Best Practice Website: Androgenic Alopecia

Initial mild-to-moderate hair loss (treatment desired)

- topical corticosteroids
- cosmetic camouflage + patient support
- topical minoxidil ± topical corticosteroid
- cosmetic camouflage + patient support

- intralesional corticosteroids
- topical minoxidil
- cosmetic camouflage + patient support
- oral corticosteroids
- topical minoxidil
- cosmetic camouflage + patient support

Initial severe hair loss (treatment desired)

- oral corticosteroids
- cosmetic camouflage + patient support

Initial hair loss (no treatment desired)

- cosmetic camouflage + patient support only

Ongoing

Chronic hair loss (treatment desired)

- topical immunotherapy
- cosmetic camouflage and patient support

Chronic hair loss (no treatment desired)

- cosmetic camouflage + patient support only

3. LEVEL N/A: EXPERT OPINION AND EVIDENCE BASED CLINICAL MANAGEMENT GUIDELINES

Guidelines for the Management of Alopecia Areata, S.P. MacDonald Hull, M.L. Wood, P.E. Hutchinson, M. Sladden, A.G. Messenger, 2003 British Association of Dermatologists, British Journal of Dermatology, 149, 692–699

The diagnosis of alopecia areata is usually straightforward although the following may cause diagnostic difficulties:

- Trichotillomania: this condition probably causes most confusion and it is possible that it coexists with alopecia areata in some cases. The incomplete nature of the hair loss in trichotillomania and the fact that the broken hairs are firmly anchored in the scalp (i.e. they remain in the growing phase, anagen, unlike exclamation mark hairs) are distinguishing features
- Tinea capitis: the scalp is inflamed in tinea capitis and there is often scaling but the signs may be subtle
- Early scarring alopecia
- Telogen effluvium
- Anagen effluvium (drug-induced) may mimic diffuse alopecia areata
- Systemic lupus erythematosus
- Secondary syphilis

Occasionally, alopecia areata presents as diffuse hair loss which can be difficult to diagnose. The clinical course often reveals the true diagnosis but a biopsy may be necessary in some cases.

Investigations: Investigations are unnecessary in most cases of alopecia areata. When the diagnosis is in doubt appropriate tests may include:

- Fungal culture
- Skin biopsy
- Serology for lupus erythematosus
- Serology for syphilis

The increased frequency of autoimmune disease in patients with alopecia areata is probably insufficient to justify routine screening.

Management: An overriding consideration in the management of alopecia areata is that, although the disease may have a serious psychological effect, it has no direct impact on general health that justifies

the use of hazardous treatments, particularly of unproven efficacy. In addition, many patients, although by no means all, experience spontaneous regrowth of hair.

Counselling: An explanation of alopecia areata, including discussion of the nature and course of the disease and the available treatments, is essential. Some patients are profoundly upset by their alopecia and may require psychological support. Contact with other sufferers and patient support groups may help patients adjust to their disability. The decision to treat alopecia areata actively should not be taken lightly. Treatment can be uncomfortable for the patient, time consuming and potentially toxic. It may also alter the patient's attitude to their hair loss. Some patients find it difficult to cope with relapse following or during initially successful treatment and they should be forewarned of this possibility. These considerations are particularly important in children where the social disruption and focusing of the child's attention on their hair loss, which may result from active treatment, have to be weighed carefully against the potential benefits. On the other hand, some patients are appreciative that something has been tried, even if it does not work.

Treatment: A number of treatments can induce hair growth in alopecia areata but none has been shown to alter the course of the disease. The high rate of spontaneous remission makes it difficult to assess efficacy, particularly in mild forms of the disease. Some trials have been limited to patients with severe alopecia areata where spontaneous remission is unlikely. However, these patients tend to be resistant to all forms of treatment and the failure of a treatment in this setting does not exclude efficacy in mild alopecia areata. Few treatments have been subjected to randomized controlled trials and, except for contact immunotherapy, there are few published data on long-term outcomes.

No treatment: Leaving alopecia areata untreated is a legitimate option for many patients. Spontaneous remission occurs in up to 80% of patients with limited patchy hair loss of short duration (< 1 year),3 although the remission rate in patients reaching secondary care is lower. Many patients may therefore be managed by reassurance alone, with advice that regrowth cannot be expected within 3 months of the development of any individual patch. The prognosis in long-standing extensive alopecia is poor. However, all treatments have a high failure rate in this group and some patients prefer not to be treated, other than wearing a wig if appropriate.

Appendix 2 – Diagnostic and Procedure Codes

Hair Replacement Technologies
GM069

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM069 – Hair Replacement Technologies	
Other specified plastic excision of skin of head or neck; plus:	S01.8
Skin of scalp	Z48.1
Unspecified plastic excision of skin of head or neck; plus:	S01.9
Skin of scalp	Z48.1
Hair bearing flap of skin to scalp for male pattern baldness	S21.1
Hair bearing flap of skin to scalp NEC	S21.2
Hair bearing flap of skin to nasolabial area	S21.3
Hair bearing flap of skin to chin area	S21.4
Other specified hair bearing flap of skin	S21.8
Unspecified hair bearing flap of skin	S21.9
Hair bearing punch graft to scalp for male pattern baldness	S33.1
Hair bearing strip graft to scalp for male pattern baldness	S33.2
Hair bearing graft to scalp for male pattern baldness NEC	S33.3
Other specified hair bearing flap of skin to scalp	S33.8
Unspecified hair bearing flap of skin to scalp	S33.9
Tattooing of skin	S60.3
With the following ICD-10 diagnosis code(s):	
Alopecia (capitis) totalis	L63.0
Alopecia universalis	L63.1
Ophiasis	L63.2
Other alopecia areata	L63.8
Alopecia areata, unspecified	L63.9
Drug-induced androgenic alopecia	L64.0
Other androgenic alopecia	L64.8
Androgenic alopecia, unspecified	L64.9
Telogen effluvium	L65.0
Anagen effluvium	L65.1

Alopecia mucinosa	L65.2
Other specified nonscarring hair loss	L65.8
Nonscarring hair loss, unspecified	L65.9

Appendix 3 – Version History

Hair Replacement Technologies
GM069

The latest version of this policy can be found here: GM Hair Replacement Technologies policy

Version	Date	Summary of Changes
0.1	30/06/2014	Initial draft
0.2	30/07/2014 17/09/2014	Amendments made following agreement by Greater Manchester EUR Steering Group on 09/07/2014: • The NHS Criteria for wigs removed and a link to the criteria included. • A sentence included under policy exclusions informing that NHS wigs provided as part of an agreed clinical pathway, e.g. cancer are excluded from the policy. Policy considered by Greater Manchester EUR Steering Group on 17/09/2014. Policy approved for consultation with no changes.
0.3	01/10/2014	Branding change following creation of North West CSU on 01/10/2014
1.0	21/11/2014	Amendments made following discussion of the Consultation feedback by the Greater Manchester EUR Steering Group on 19/11/2014: • Under Section 2 Definition - a description added for hair weaves added. • Under mandatory criteria a sentence added that these technologies are not commissioned for failure of hair growth following the end of a course of treatment that caused the initial loss. • The EUR Steering Group approved the policy subject to the above amendments being made.
1.1	29/06/2015	• Variance column removed and funding mechanism column added to table. • Format of funding mechanism changed.
1.2	06/04/2016	• List of diagnostic and procedure codes in relation to this policy added as Appendix 2. • Policy changed to Greater Manchester Shared Services template and references to North West Commissioning Support Unit changed to Greater Manchester Shared Services. • Wording for date of review amended to read *"One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)"* on 'Policy Statement' and section '13. Date of Review'.
2.0	05/08/2016	Evidence reviewed June 1016 – no new studies or reviews found. GM EUR Steering Group agreed: • No changes to policy other than the "Date of Review" on "Policy Statement" and in body of report changed to *"Three years from the date of last review unless new evidence warrants earlier review."* • Review date added to cover page and 'Policy Statement'.
2.1	21/03/2018	• Policy transferred to new template The GM EUR Steering Group agreed following amendments to the policy: • *'For Alopecia'* removed from policy throughout so that policy covers any part of body

2.2	25/01/2019	• Branding changed to reflect change of service from Greater Manchester Shared Services to Greater Manchester Health and Care Commissioning. • Links updated as documents have all moved to a new EUR web address. • Commissioning Statement: *'Best Practice Guideline'* section added