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Treatment of pediatric alopecia areata: A systematic review

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Abstract

Background: Alopecia areata (AA) is an autoimmune, nonscarring hair loss disorder with slightly greater prevalence in children than adults. Various treatment modalities exist; however, their evidence in pediatric AA patients is lacking.

Objective: To evaluate the evidence of current treatment modalities for pediatric AA.

Methods: We conducted a systematic review on the PubMed database in October 2019 for all published articles involving patients <18 years old. Articles discussing AA treatment in pediatric patients were included, as were articles discussing both pediatric and adult patients, if data on individual pediatric patients were available.

Results: Inclusion criteria were met by 122 total reports discussing 1032 patients. Reports consisted of 2 randomized controlled trials, 4 prospective comparative cohorts, 83 case series, 2 case-control studies, and 31 case reports. Included articles assessed the use of aloe, apremilast, anthralin, anti-interferon gamma antibodies, botulinum toxin, corticosteroids, contact immunotherapies, cryotherapy, hydroxychloroquine, hypnotherapy, imiquimod, Janus kinase inhibitors, laser and light therapy, methotrexate, minoxidil, phototherapy, psychotherapy, prostaglandin analogs, sulfasalazine, topical calcineurin inhibitors, topical nitrogen mustard, and ustekinumab.

Limitations: English-only articles with full texts were used. Manuscripts with adult and pediatric data were only incorporated if individual-level data for pediatric patients were provided. No meta-analysis was performed.

Conclusion: Topical corticosteroids are the preferred first-line treatment for pediatric AA, as they hold the highest level of evidence, followed by contact immunotherapy. More clinical trials and comparative studies are needed to further guide management of pediatric AA and to promote the potential use of pre-existing, low-cost, and novel therapies, including Janus kinase inhibitors.

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Conflicts of interest
None disclosed.

Keywords

alopecia areata; contact immunotherapy; corticosteroids; JAK inhibitors; pediatric; quality of life

Alopecia areata (AA) is a nonscarring hair loss disorder that affects up to 2% of the global population.¹ It is estimated that nearly 80% of patients with limited, patchy AA spontaneously recover.² AA is characterized by relapsing and remitting patches of hair loss that may progress to severe subtypes, such as alopecia totalis (AT), alopecia universalis (AU), or alopecia ophiasis (AO), often resulting in significant psychological detriment. The pediatric population is particularly susceptible to the psychosocial consequences of AA, thus, adequate treatment is critical to prevent further morbidity associated with this disease.³ Although there are currently no treatments for AA approved by the Food and Drug Administration, there are numerous off-label treatment options for adults with AA. Therapeutic options for children and adolescents are limited. This systematic review sought to evaluate available off-label therapies for the treatment of AA in patients younger than 18 years of age.

METHODS

A systematic review was conducted according to the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines (Supplemental Table I; available via Mendeley at <https://doi.org/10.17632/s9rx4myvnn.1>). Using the PubMed database, a search for all published peer-reviewed articles was performed using the following search terms: “alopecia” and “areata” or “totalis” or “universalis” or “ophiasis” and “treatment” or “therapy” or “medication” or “drug.”

These records were screened using defined criteria for eligibility, which consisted of English articles discussing the direct study or report of treatment modalities for AA in humans younger than 18 years of age. References of included reports were examined and additional sources not identified initially were incorporated. Review articles, animal studies, articles evaluating treatments that are no longer manufactured worldwide, including alefacept, and articles with unavailable full text were excluded. Articles that reported on results for both pediatric and adult patients were only included if individual-level data for the pediatric patients were provided.

The results were then further classified by the Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence (LoE): level 1 (systematic review of randomized controlled trials [RCTs] or high-quality randomized controlled trial), level 2 (lesser quality RCT or prospective cohort study), level 3 (case-control study, non-randomized controlled cohort or follow-up study), level 4 (case series), or level 5 (expert opinion, mechanism-based reasoning).

RESULTS

A total of 707 publications were retrieved, of which 122 reports were included (Fig 1). These reports consisted of 2 RCTs, 4 prospective comparative cohorts, 83 case series, 2

case-control studies, and 31 case reports. Included articles and results are summarized in Tables I to III.^{4–18}

Topical therapies

Anthralin.—Use of the irritant anthralin to treat AA in pediatric patients was demonstrated in 4 case series or reports, including 69 patients (strongest LoE 4; Table I).^{19–22} Complete response rates ranged between 32% and 33.3% with relapse rates of 9.5% to 64%. One case reported complete regrowth when combined with leflunomide.¹⁹ The mean time to maximal response was approximately 9 to 15 months.^{19–22} Anthralin caused staining of the skin and regional lymphadenopathy (LAD), which resolved after cessation of treatment. Other side effects were itching, burning, oozing, and bullous eruptions, but systemic side effects were rare.¹¹⁸

Contact immunotherapy.

Diphenylcyclo propenone. Treatment of the affected areas with diphenylcyclopropenone (DPCP) includes sensitization prior to initial treatment and escalating dose concentrations. The essentially painless application method makes DPCP an ideal and frequently utilized treatment option for the pediatric population. Eight articles reported DPCP treatment in 200 children with AA (strongest LoE 3).^{23–30} Complete response rates ranged from 0% to 33.3%, similar to the results of a meta-analysis (30.7%).¹¹⁹ Relapses were common, with relapse rates ranging from 12.5% to 58.3%.^{28,29,30} One case-control study noted the potential of imiquimod to improve DPCP efficacy.²³ Side effects included eczematous reactions of the scalp, pruritus, regional LAD, vesiculation, or, rarely, a secondary infection.²⁹ No systemic side effects except headache were reported.

Squaric acid dibutyl ester. The efficacy of squaric acid dibutyl ester (SADBE) was studied in 78 pediatric patients (strongest LoE 4). Complete response rates ranged from 0% to 33.3%.^{33–35} A meta-analysis including adult and pediatric patients demonstrated slightly better complete response rates with SADBE (38.4%) than with DPCP (30.7%).¹¹⁹ Relapse rates ranged between 62.5% and 100%. Side effects included irritation, itching, LAD, and contact dermatitis.³¹ There was 1 case of epidermolysis bullosa acquisita that arose during treatment of AA with SADBE and regressed upon discontinuation.³² There was no evidence of systemic absorption through topical application.¹²⁰

Cryotherapy.—One case series documented the use of cryotherapy in 24 patients <10 years of age and 40 patients between the ages of 10 and 20 (strongest LoE 4). Complete response was seen in 20.8% of patients <10 years of age. Side effects were localized, but included pain, pruritus, inflammation, and swelling.^{36,121}

Minoxidil.—Minoxidil's efficacy is equivocal for adult AA¹²² and only case reports exist evaluating its use in 9 children (strongest LoE 4). Minoxidil is mostly used as an adjunctive therapy.^{41,83} Side effects of minoxidil included extensive hypertrichosis.^{37–40,42} Although excessive topical administration may lead to systemic absorption (manifesting as palpitations, hypotension, etc.), the typical twice daily dose is generally safe.¹²³

Topical calcineurin inhibitors.—The consensus of 4 studies that included 7 pediatric AA patients is that topical calcineurin inhibitors, tacrolimus and pimecrolimus, are not effective for the treatment of AA (strongest LoE 2). Approximately 29% showed only a minimal response,⁴⁴ while the remaining 71% showed no response and often experienced disease progression.^{45–47,124}

Topical and intralesional corticosteroids.—The use of topical corticosteroids, particularly high-potency topical corticosteroids, is supported by the literature (strongest LoE 1) and is considered a safe and effective first-line treatment option in children with patchy AA. High-potency topical corticosteroids showed a higher efficacy than low-potency topical corticosteroids in a RCT that included 41 pediatric patients.⁵⁰ They were also superior to topical tacrolimus⁴⁴ and anthralin²² and were often used as adjunctive therapies.^{49,51,63,83} High-potency topical corticosteroids were generally well tolerated in children. Side effects included skin atrophy, telangiectasias, and folliculitis. Although intralesional corticosteroid (triamcinolone) therapy is effective, these studies are rare in children due to the pain associated with the injections.⁴⁸ Based on data on adult patients, the most common side effects are pain, skin atrophy, and dyspigmentation. Other adverse effects are rare, although anaphylaxis and cataracts and increased intraocular pressure, if used close to the eyes, have been reported.¹²⁵

Prostaglandins.—Topical prostaglandins, including bimatoprost and latanoprost, may improve the regrowth of scalp and eyelash hair (strongest LoE 1–2) in AA,^{52–56} although statistically significant differences between bimatoprost and vehicle were not found in a RCT examining eyelash hair growth in pediatric AA patients.⁵² While prostaglandins, specifically latanoprost, can cause irreversible iris and eyelid hyperpigmentation, uveitis, eyelash curling, and conjunctival hyperemia, these side effects were not reported in patients with AA.^{52–56,126}

Systemic therapies

Corticosteroids.—Systemic corticosteroid therapy was the most studied treatment modality for AA in both children and adults, comprising 27 studies, mostly case series, that included 272 pediatric patients (strongest LoE 2; Table II). The studies included combination therapy with an adjunctive systemic drug including methotrexate or cyclosporine,^{60–62,68,72} intravenous pulse-dosed corticosteroids,^{68,70–74,77,79,81,82} oral pulse-dosed corticosteroids,^{49,60,69,71,75,76,78,80} oral corticosteroid maintenance or tapered therapy,^{61,62,64–67} and intramuscular corticosteroids.^{57–59}

Although doses and frequencies varied among each route of administration, approximately 45% (range 0% to 100%) of patients receiving intravenous or oral pulse-dosed corticosteroids demonstrated a complete response and 34% (range 0% to 55.5%) of patients receiving traditional oral corticosteroid regimens demonstrated a complete response. For pulse-dosed therapy, shorter disease duration, younger age at disease onset, and multifocal disease (as opposed to AT and AU) were found to be associated with a better response.⁷¹ Relapse rates ranged between 16.7 and 100% for pulse-dosed and 50% and 100% for non-pulse-dosed corticosteroids.^{59,64} Significant side effects were reported, including weight

gain, cataracts, infections, hypertension, Cushingoid features, psychiatric disturbances, striae, and acne. Side effects were greater and more frequent for non-pulse-dosed regimens (Table II).^{127,128}

Hydroxychloroquine.—A single case series of 9 pediatric patients examined the use of hydroxychloroquine (strongest LoE 4). When used in conjunction with topical corticosteroids and/or minoxidil, complete response was seen in 11% and partial response in 55% of patients.⁸³ Reported side effects included abdominal pain and headache.⁸³

Methotrexate.—Eight articles reported studies of methotrexate, either as a solitary agent or in conjunction with oral or intravenous corticosteroids or azathioprine, for the treatment of AA in 42 pediatric patients (strongest LoE 4).^{60,68,72,84–88} Complete response was seen on average in 17.9% (range 0% to 50%; Table II) and partial response in 47.9% (range 0% to 100%) with doses ranging from 2.5 mg to 25 mg per week.^{60,72,85–88} A meta-analysis revealed a higher complete response in adult versus pediatric AA patients (44.7% vs 11.6%), although the relapse rate in children was significantly lower than that in adults (31.7% vs 52%).¹²⁹ Reported side effects included nausea, elevations in hepatic transaminases, and hematologic changes (Table II).

Sulfasalazine and mesalazine.—Limited data exist for the use of sulfasalazine and mesalazine for pediatric AA (strongest LoE 4). Complete response to mesalazine, with or without concurrent oral or topical corticosteroids and minoxidil, was reported in 1 case series of 5 pediatric patients.⁸⁹ Ten adolescent AA patients treated with oral sulfasalazine in 2 studies all demonstrated partial response with a starting dose of 1 g/week, which was escalated to a final dose of 3 g/week.^{90,91} Side effects for sulfasalazine included dizziness, headache, and dyspepsia (Table II). This was similar to the side-effect profile in adults, which included gastrointestinal distress, rash, headache, and lab abnormalities.¹³⁰

Ustekinumab.—A report of 3 adults whose AA responded to ustekinumab, a monoclonal antibody used for psoriasis that blocks interleukins 12 and 23,¹³¹ prompted the treatment in pediatric AA and AT patients with variable results (strongest LoE was 4). One case series showed a complete or partial response in all 3 patients, while the other study reported no response.^{92,93} Although injection-site reactions, infections, nausea, and vomiting are known side effects of ustekinumab, none were reported in these 2 studies.

Janus kinase inhibitors.—Increasing evidence suggests that JAK inhibitors may be effective in the treatment of AA, but data in children are limited (strongest LoE 4). Side effects included infections, diarrhea, hypertension, thrombosis, gastrointestinal perforation, laboratory abnormalities, and hematologic malignancies.¹³²

Baricitinib. Clinical trials have been initiated to evaluate the safety and efficacy of baricitinib for the treatment of AA in adults but not yet in children.^{133,134} Only 1 pediatric case has been reported (strongest LoE 5). A 17-year-old male with a longstanding history of recalcitrant AA initially showed a partial response with baricitinib 7 mg once daily, followed by a complete response when the dose was increased to 11 mg once daily.⁹⁴ No relapse was reported.

Ruxolitinib.: A case series of 8 AA patients treated with ruxolitinib included only 1 pediatric patient, who was treated with ruxolitinib 10 mg twice daily for 10 months and experienced a 91% improvement in the Severity of Alopecia Tool score with no adverse events.¹⁰¹

Tofacitinib.: Clinical trials are currently evaluating the efficacy of tofacitinib to treat AA in adults.⁹⁹ Six case series and reports evaluated systemic tofacitinib for the treatment of AA in 28 pediatric patients.^{95–100} Of these patients, 82% showed complete or partial response and all nonresponders were patients with AU. Similarly, adults with severe AT or AU present for >10 years were less likely to respond to tofacitinib.¹⁰⁰ Side effects included diarrhea, headaches, upper respiratory infection, increased appetite, weight gain, fatigue, and transient elevation in transaminases.

Topical tofacitinib and ruxolitinib.: In 3 reports documenting a total of 18 pediatric patients, 13 responded to topical therapy.^{102–104} Side effects included application site irritation¹⁰² and 1 case of borderline leukopenia in a patient with baseline low white blood cell count.¹⁰⁴

Laser and phototherapy

Laser therapy.—Seventeen patients received treatment with a 308 nm excimer laser twice weekly with 58.8% response rate (strongest LoE 4).^{105–108} Side effects included mild scalp erythema and desquamation.

Phototherapy.—There were 6 reports involving 26 pediatric AA patients treated with psoralen and ultraviolet A therapy (strongest LoE 4).^{110–115,117} All 5 adolescents treated with a psoralen-soaked towel followed by sun exposure demonstrated partial response.¹¹⁶ Narrow-band ultraviolet B therapy was largely ineffective in pediatric patients,¹⁰⁹ similar to the results in adults.¹³⁵ Mild irritation, erythema, pruritus, and scaling were noted as side effects of phototherapy, similar to adult patients with AA.¹¹⁶

DISCUSSION

AA is an immune-mediated disease causing non-scarring hair loss with significant psychosocial impact.¹ While a majority of children with limited AA spontaneously recover, the variability of the disease course and unpredictable response to therapy make AA challenging to treat. Although numerous therapies have been reported, the evidence is mostly weak. As a general guideline, low-risk topical therapies are a reasonable option for limited AA, while higher-risk systemic therapies may be warranted for patients who have extensive AA refractory to other therapies and who experience a significant psychosocial impact.

A limited number of trials have been conducted in pediatric AA patients, mostly involving topical corticosteroids.^{44,50} These studies provide the highest LoE for treatment with high-potency topical corticosteroids and have led to their preference as first-line therapy for pediatric AA. While intralesional corticosteroids are recommended as first-line treatment for patchy AA in adults,¹³⁶ their use in children is limited by pain.¹³⁷ Systemic steroids also

can be efficacious, particularly in patients with a shorter disease duration, those who are at a younger age at disease onset, and those with multifocal disease⁷¹; however, their use is limited by significant side effects.^{127,128}

Other treatment options include contact immunotherapy with DPCP or SADBE, although evidence in children is limited to case series^{24–30,33–35} (Table I). Protocols for the application of SADBE at home have been utilized more recently, increasing its convenience but increasing out-of-pocket cost when purchasing SADBE from compounding pharmacies. With respect to topical adjuvant therapy, minoxidil is commonly used as the “go-to” secondary agent in clinical practice, but our evidence does not support its use as a first-line agent¹²² (Table I). Topical calcineurin inhibitors are ineffective.^{45–47,124}

A better understanding of the molecular pathogenesis of AA has resulted in the development of targeted therapies, including JAK inhibitors. Current clinical trials for adults with AA include treatment with tofacitinib, ruxolitinib, and baricitinib.¹³³ Furthermore, clinical trials have been initiated recently to evaluate a JAK inhibitor, PF-06651600, for AA treatment in adults and adolescents older than 12 years of age.¹³³ If pediatric data are able to reflect preliminary adult responses to systemic JAK inhibitors, these currently show promise as potential future therapies, but more trials, including trials with pediatric patients, are needed. While systemic JAK inhibitors may be an effective new therapy, their safety profile as well as cost may significantly limit their use to severe, treatment-refractory cases.^{99,132}

It is also important to counsel patients and families regarding the chronicity of AA and the relapsing and remitting nature of the disease. Because of the lack of an evidence-based treatment algorithm, we recommend counseling patients and their families on the wide range of severity and varied responses to treatment among the different AA subtypes. Specifically, most data on AA are generalized from heterogeneous groups of individuals, including patients with AT and AU. Subtype-specific response to treatment is not well-documented; however, it is known that the AT and AU subtypes generally bode more recalcitrant disease and worse outcomes. Clinicians should also highlight the existence and impact of AA comorbidities, particularly co-occurring autoimmune conditions, such as vitiligo, which add to the psychosocial impact of an AA diagnosis and can have long-lasting effects on self-esteem during childhood.¹³⁸

CONCLUSIONS

Pediatric AA has a variable disease course with significant psychosocial impact. Although topical corticosteroids remain the preferred first-line treatment for pediatric AA, RCTs, and prospective comparative studies are needed to help define treatment guidelines. Additionally, a better understanding of prognostic markers in AA would be valuable.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Abbreviations used:

AA	alopecia areata
AO	alopecia ophiasis
AT	alopecia totalis
AU	alopecia universalis
DPCP	diphenylcyclopropenone
LAD	lymphadenopathy
LoE	Levels of Evidence
PRISMA	Preferred Reporting Items for Systematic Review and Meta-Analyses
RCT	randomized controlled trial
SADBE	squaric acid dibutyl ester

REFERENCES

1. Lee HH, Gwillim E, Patel KR, et al. Epidemiology of alopecia areata, ophiasis, totalis, and universalis: a systematic review and meta-analysis. *J Am Acad Dermatol* 2020;82(3):675–682. [PubMed: 31437543]
2. Ito T Advances in the management of alopecia areata. *J Dermatol* 2012;39(1):11–17. [PubMed: 22211297]
3. Christensen T, Yang JS, Castelo-Soccio L. Bullying and quality of life in pediatric alopecia areata. *Skin Appendage Disord* 2017;3(3):115–118. [PubMed: 28879186]
4. Liu LY, King BA. Lack of efficacy of apremilast in 9 patients with severe alopecia areata. *J Am Acad Dermatol* 2017;77(4): 773–774. [PubMed: 28917463]
5. Cho HR, Lew BL, Lew H, Sim WY. Treatment effects of intradermal botulinum toxin type A injection on alopecia areata. *Dermatol Surg* 2010;36(Suppl 4):2175–2181. [PubMed: 21134049]
6. Sarifakioglu E, Degim IT, Gorpelioglu C. Determination of the sildenafil effect on alopecia areata in childhood: an open-pilot comparison study. *J Dermatolog Treat* 2006;17(4):235–237. [PubMed: 16971319]
7. Fessatou S, Kostaki M, Karpathios T. Coeliac disease and alopecia areata in childhood. *J Paediatr Child Health* 2003; 39(2):152–154. [PubMed: 12603809]
8. Boonyaleepun S, Boonyaleepun C, Schlactus JL. Effect of IVIG on the hair regrowth in a common variable immune deficiency patient with alopecia universalis. *Asian Pac J Allergy Immunol* 1999;17(1):59–62. [PubMed: 10403010]
9. Shibuya A, Shinozawa T, Danya N, Maeda K. Successful bone marrow transplant and re-growth of hair in a patient with posthepatic aplastic anemia complicated by alopecia totalis. *Acta Paediatr Jpn* 1990;32(5):552–554. [PubMed: 2126659]
10. Rozin AP, Schapira D, Bergman R. Alopecia areata and relapsing polychondritis or mosaic autoimmunity? The first experience of co-trimoxazole treatment. *Ann Rheum Dis* 2003;62(8):778–780. [PubMed: 12860737]

11. Zawahry ME, Hegazy MR, Helal M. Use of aloe in treating leg ulcers and dermatoses. *Int J Dermatol* 1973;12(1):68–73. [PubMed: 4266516]
12. Skurkovich S, Korotky NG, Sharova NM, Skurkovich B. Treatment of alopecia areata with anti-interferon-gamma antibodies. *J Investig Dermatol Symp Proc* 2005;10(3):283–284.
13. Willemsen R, Vanderlinden J, Deconinck A, Roseeuw D. Hypnotherapeutic management of alopecia areata. *J Am Acad Dermatol* 2006;55(2):233–237. [PubMed: 16844504]
14. Letada PR, Sparling JD, Norwood C. Imiquimod in the treatment of alopecia universalis. *Cutis* 2007;79(2):138–140. [PubMed: 17388216]
15. Koblenzer CS. Psychotherapy for intractable inflammatory dermatoses. *J Am Acad Dermatol* 1995;32(4):609–612. [PubMed: 7896951]
16. Putt SC, Weinstein L, Dzindolet MT. A case study: massage, relaxation, and reward for treatment of alopecia areata. *Psychol Rep* 1994;74(3 Pt 2):1315–1318. [PubMed: 8084951]
17. Teshima H, Sogawa H, Mizobe K, Kuroki N, Nakagawa T. Application of psychoimmunotherapy in patients with alopecia universalis. *Psychother Psychosom* 1991;56(4): 235–241. [PubMed: 1801046]
18. Arrazola JM, Sendagorta E, Harto A, Ledo A. Treatment of alopecia areata with topical nitrogen mustard. *Int J Dermatol* 1985;24(9):608–610. [PubMed: 4066107]
19. Sardana K, Gupta A, Gautam RK. Recalcitrant alopecia areata responsive to leflunomide and anthralin-potentially undiscovered JAK/STAT inhibitors? *Pediatr Dermatol* 2018;35(6): 856–858. [PubMed: 30318623]
20. Wu SZ, Wang S, Ratnaparkhi R, Bergfeld WF. Treatment of pediatric alopecia areata with anthralin: a retrospective study of 37 patients. *Pediatr Dermatol* 2018;35(6):817–820. [PubMed: 30338548]
21. Özdemir M, Balevi A. Bilateral half-head comparison of 1% anthralin ointment in children with alopecia areata. *Pediatr Dermatol* 2017;34(2):128–132. [PubMed: 28044367]
22. Torchia D, Schachner LA. Bilateral treatment for alopecia areata. *Pediatr Dermatol* 2010;27(4):415–416. [PubMed: 20653874]
23. Wasylyszyn T, Borowska K. Possible advantage of imiquimod and diphenylcyclopropenone combined treatment versus diphenylcyclopropenone alone: an observational study of nonresponder patients with alopecia areata. *Australas J Dermatol* 2017;58(3):219–223. [PubMed: 27087586]
24. Luk NM, Chiu LS, Lee KC, et al. Efficacy and safety of diphenylcyclopropenone among Chinese patients with steroid resistant and extensive alopecia areata. *J Eur Acad Dermatol Venereol* 2013;27(3):e400–e405. [PubMed: 23057682]
25. Salsberg JM, Donovan J. The safety and efficacy of diphenylcyclopropenone for the treatment of alopecia areata in children. *Arch Dermatol* 2012;148(9):1084–1085. [PubMed: 22986874]
26. Singh G, Okade R, Naik C, Dayanand CD. Diphenylcyclopropenone immunotherapy in ophiasis. *Indian J Dermatol Venereol Leprol* 2007;73(6):432–433. [PubMed: 18032873]
27. Sotiriadis D, Patsatsi A, Lazaridou E, Kastanis A, Vakirlis E, Chrysomallis F. Topical immunotherapy with diphenylcyclopropenone in the treatment of chronic extensive alopecia areata. *Clin Exp Dermatol* 2007;32(1):48–51. [PubMed: 17004987]
28. Schuttelaar ML, Hamstra JJ, Plinck EP, et al. Alopecia areata in children: treatment with diphenylcyclopropenone. *Br J Dermatol* 1996; 135(4):581–585. [PubMed: 8915150]
29. Hull SM, Pepall L, Cunliffe WJ. Alopecia areata in children: response to treatment with diphenylcyclopropenone. *Br J Dermatol* 1991;125(2):164–168. [PubMed: 1911299]
30. Orecchia G, Rabbiosi G. Treatment of alopecia areata with diphenylcyclopropenone. *Dermatologica* 1985;171(3):193–196. [PubMed: 4076492]
31. Chen CA, Carlberg V, Kroshinsky D. Angioedema after squaric acid treatment in a 6-year-old girl. *Pediatr Dermatol* 2017; 34(1):e44–e46. [PubMed: 27699860]
32. Guerra L, Pacifico V, Calabresi V, et al. Childhood epidermolysis bullosa acquisita during squaric acid dibutyl ester immunotherapy for alopecia areata. *Br J Dermatol* 2017; 176(2):491–494. [PubMed: 27208509]

33. Tosti A, Guidetti MS, Bardazzi F, Misciali C. Long-term results of topical immunotherapy in children with alopecia totalis or alopecia universalis. *J Am Acad Dermatol* 1996;35(2 Pt 1):199–201. [PubMed: 8708020]
34. Orecchia G, Malagoli P. Topical immunotherapy in children with alopecia areata. *J Invest Dermatol* 1995;104(5 suppl):35S–36S. [PubMed: 7738389]
35. Giannetti A, Orecchia G. Clinical experience on the treatment of alopecia areata with squaric acid dibutyl ester. *Dermatologica* 1983;167(5):280–282. [PubMed: 6653853]
36. Jun M, Lee NR, Lee WS. Efficacy and safety of superficial cryotherapy for alopecia areata: a retrospective, comprehensive review of 353 cases over 22 years. *J Dermatol* 2017;44(4): 386–393. [PubMed: 27711995]
37. Rai AK. Minoxidil-induced hypertrichosis in a child with alopecia areata. *Indian Dermatol Online J* 2017;8(2):147–148. [PubMed: 28405563]
38. Guerouaz N, Mohamed AO. Minoxidil induced hypertrichosis in children. *Pan Afr Med J* 2014;18:8.
39. Herskovitz I, Freedman J, Tosti A. Minoxidil induced hypertrichosis in a 2 year-old child. *F1000Res* 2013;2:226. [PubMed: 24555107]
40. Georgala S, Befon A, Maniatopoulou E, Georgala C. Topical use of minoxidil in children and systemic side effects. *Dermatology* 2007;214(1):101–102. [PubMed: 17191059]
41. Lenane P, Pope E, Krafchik B. Congenital alopecia areata. *J Am Acad Dermatol* 2005;52(2 suppl 1):8–11. [PubMed: 15692503]
42. Baral J. Minoxidil and tail-like effect. *Int J Dermatol* 1989; 28(2):140. [PubMed: 2737812]
43. Weiss VC, West DP, Mueller CE. Topical minoxidil in alopecia areata. *JAAD* 1981. 10.1016/s0190-9622(81)80077-1
44. Jung KE, Gye JW, Park MK, Park BC. Comparison of the topical FK506 and clobetasol propionate as first-line therapy in the treatment of early alopecia areata. *Int J Dermatol* 2017; 56(12):1487–1488. [PubMed: 28703306]
45. Rigopoulos D, Gregoriou S, Korfitis C, et al. Lack of response of alopecia areata to pimecrolimus cream. *Clin Exp Dermatol* 2007;32(4):456–457. [PubMed: 17537231]
46. Price VH, Willey A, Chen BK. Topical tacrolimus in alopecia areata. *J Am Acad Dermatol* 2005;52(1):138–139. [PubMed: 15627095]
47. Thiers BH. Topical tacrolimus: treatment failure in a patient with alopecia areata. *Arch Dermatol* 2000;136(1):124.
48. Sankararaman S, Bobonich M, Aktay AN. Alopecia areata in an adolescent with inflammatory bowel disease. *Clin Pediatr* 2017;56(14):1350–1352.
49. Lalosevic J, Gajic-Veljic M, Bonaci-Nikolic B, Nikolic M. Combined oral pulse and topical corticosteroid therapy for severe alopecia areata in children: a long-term follow-up study. *Dermatol Ther* 2015;28(5):309–317. [PubMed: 26179196]
50. Lenane P, Macarthur C, Parkin PC, et al. Clobetasol propionate, 0.05%, vs hydrocortisone, 1%, for alopecia areata in children: a randomized clinical trial. *JAMA Dermatol* 2014;150(1):47–50. [PubMed: 24226568]
51. Montes LF. Topical halcinonide in alopecia areata and in alopecia totalis. *J Cutan Pathol* 1977;4(2):47–50. [PubMed: 915049]
52. Borchert M, Bruce S, Wirta D, et al. An evaluation of the safety and efficacy of bimatoprost for eyelash growth in pediatric subjects. *Clin Ophthalmol* 2016;10:419–429. [PubMed: 27022239]
53. Li AW, Antaya RJ. Successful treatment of pediatric alopecia areata of the scalp using topical bimatoprost. *Pediatr Dermatol* 2016;33(5):e282–e283. [PubMed: 27377163]
54. Zaheri S, Hughes B. Successful use of bimatoprost in the treatment of alopecia of the eyelashes. *Clin Exp Dermatol* 2010;35(4):e161–e162. [PubMed: 19925481]
55. Yadav S, Dogra S, Kaur I. An unusual anatomical colocalization of alopecia areata and vitiligo in a child, and improvement during treatment with topical prostaglandin E2. *Clin Exp Dermatol* 2009;34(8):e1010–e1011. [PubMed: 20055821]
56. Mehta JS, Raman J, Gupta N, Thoung D. Cutaneous latanoprost in the treatment of alopecia areata. *Eye* 2003;17(3):444–446. [PubMed: 12724722]

57. Seo J, Lee YI, Hwang S, Zheng Z, Kim DY. Intramuscular triamcinolone acetonide: an undervalued option for refractory alopecia areata. *J Dermatol* 2017;44(2):173–179. [PubMed: 27448451]
58. Sato-Kawamura M, Aiba S, Tagami H. Acute diffuse and total alopecia of the female scalp. A new subtype of diffuse alopecia areata that has a favorable prognosis. *Dermatology* 2002;205(4):367–373. [PubMed: 12444333]
59. Michalowski R, Kuczynska L. Long-term intramuscular triamcinolon-acetonide therapy in alopecia areata totalis and universalis. *Arch Dermatol Res* 1978;261(1):73–76. [PubMed: 147647]
60. Anuset D, Perceau G, Bernard P, Reguiat Z. Efficacy and safety of methotrexate combined with low- to moderate-dose corticosteroids for severe alopecia areata. *Dermatology* 2016;232(2):242–248. [PubMed: 26735937]
61. Gensure RC. Clinical response to combined therapy of cyclosporine and prednisone. *J Investig Dermatol Symp Proc* 2013;16(1):S58.
62. Kim BJ, Uk min S, Park KY, et al. Combination therapy of cyclosporine and methylprednisolone on severe alopecia areata. *J Dermatol Treat* 2008;19(4):216–220.
63. Camacho FM, Garcia-Hernandez MJ. Zinc aspartate, biotin, and clobetasol propionate in the treatment of alopecia areata in childhood. *Pediatr Dermatol* 1999; 16(4):336–338.
64. Alabdulkareem AS, Abahussein AA, Okoro A. Severe alopecia areata treated with systemic corticosteroids. *Int J Dermatol* 1998;37(8):622–624. [PubMed: 9732014]
65. Schindler AM. The boy whose hair came back. *Hosp Pract* 1987;22(9):185–188.
66. Unger WP, Schemmer RJ. Corticosteroids in the treatment of alopecia totalis. Systemic effects. *Arch Dermatol* 1978; 114(10):1486–1490. [PubMed: 718184]
67. Winter RJ, Kern F, Blizzard RM. Prednisone therapy for alopecia areata. A follow-up report. *Arch Dermatol* 1976; 112(11):1549–1552. [PubMed: 791152]
68. Chong JH, Taieb A, Morice-Picard F, Dutkiewicz AS, Léauté-Labrèze C, Boralevi F. High-dose pulsed corticosteroid therapy combined with methotrexate for severe alopecia areata of childhood. *J Eur Acad Dermatol Venereol* 2017; 31(11):e476–e477. [PubMed: 28426924]
69. Jahn-Bassler K, Bauer WM, Karlhofer F, Vossen MG, Stingl G. Sequential high- and low-dose systemic corticosteroid therapy for severe childhood alopecia areata. *J Dtsch Dermatol Ges* 2017;15(1):42–47.
70. Smith A, Trüeb RM, Theiler M, Hauser V, Weibel L. High relapse rates despite early intervention with intravenous methylprednisolone pulse therapy for severe childhood alopecia areata. *Pediatr Dermatol* 2015;32(4):481–487. [PubMed: 25872976]
71. Friedland R, Tal R, Lapidot M, Zvulunov A, Ben Amitai D. Pulse corticosteroid therapy for alopecia areata in children: a retrospective study. *Dermatology* 2013;227(1):37–44. [PubMed: 24008264]
72. Droitcourt C, Milpied B, Ezzedine K, et al. Interest of high-dose pulse corticosteroid therapy combined with methotrexate for severe alopecia areata: a retrospective case series. *Dermatology* 2012;224(4):369–373. [PubMed: 22738995]
73. Sauerbrey A. Successful immunosuppression in childhood alopecia areata. *Klin Padiatr* 2011;223(4):244–245. [PubMed: 21509708]
74. Hubiche T, Léauté-Labrèze C, Taïeb A, Boralevi F. Poor long term outcome of severe alopecia areata in children treated with high dose pulse corticosteroid therapy. *Br J Dermatol* 2008;158(5):1136–1137. [PubMed: 18279461]
75. Sethuraman G, Malhotra AK, Sharma VK. Alopecia universalis in Down syndrome: response to therapy. *Indian J Dermatol Venereol Leprol* 2006;72(6):454–455. [PubMed: 17179625]
76. Bin Saif GA. Oral mega pulse methylprednisolone in alopecia universalis. *Saudi Med J* 2006;27(5):717–720. [PubMed: 16680269]
77. Seiter S, Ugurel S, Tilgen W, Reinhold U. High-dose pulse corticosteroid therapy in the treatment of severe alopecia areata. *Dermatology* 2001;202(3):230–234. [PubMed: 11385229]
78. Sharma VK, Gupta S. Twice weekly 5 mg dexamethasone oral pulse in the treatment of extensive alopecia areata. *J Dermatol* 1999;26(9):562–565. [PubMed: 10535249]

79. Friedli A, Labarthe MP, Engelhardt E, Feldmann R, Salomon D, Saurat JH. Pulse methylprednisolone therapy for severe alopecia areata: an open prospective study of 45 patients. *J Am Acad Dermatol* 1998;39(4):597–602. [PubMed: 9777767]
80. Sharma VK, Muralidhar S. Treatment of widespread alopecia areata in young patients with monthly oral corticosteroid pulse. *Pediatr Dermatol* 1998;15(4):313–317. [PubMed: 9720702]
81. Kiesch N, Stene JJ, Goens J, Vanhootehem O, Song M. Pulse steroid therapy for children's severe alopecia areata? *Dermatology* 1997;194(4):395–397. [PubMed: 9252774]
82. Perriard-Wolfensberger J, Pasche-Koo F, Mainetti C, Labarthe MP, Salomon D, Saurat JH. Pulse of methylprednisolone in alopecia areata. *Dermatology* 1993;187(4):282–285. [PubMed: 8274789]
83. Yun D, Silverberg NB, Stein SL. Alopecia areata treated with hydroxychloroquine: a retrospective study of nine pediatric cases. *Pediatr Dermatol* 2018;35(3):361–365. [PubMed: 29575039]
84. Mascia P, Milpied B, Darrigade AS, et al. Azathioprine in combination with methotrexate: a therapeutic alternative in severe and recalcitrant forms of alopecia areata? *J Eur Acad Dermatol Venereol* 2019;33(12):e494–e495. [PubMed: 31374131]
85. Landis ET, Pichardo-Geisinger RO. Methotrexate for the treatment of pediatric alopecia areata. *J Dermatolog Treat* 2018;29(2):145–148. [PubMed: 28627278]
86. Batalla A, Flórez Á, Abalde T, Vázquez-Veiga H. Methotrexate in alopecia areata: a report of three cases. *Int J Trichology* 2016;8(4):188–190. [PubMed: 28442879]
87. Lucas P, Bodemer C, Barbarot S, Vabres P, Royer M, Mazereeuw-Hautier J. Methotrexate in severe childhood alopecia areata: long-term follow-up. *Acta Derm Venereol* 2016;96(1): 102–103.
88. Royer M, Bodemer C, Vabres P, et al. Efficacy and tolerability of methotrexate in severe childhood alopecia areata. *Br J Dermatol* 2011;165(2):407–410. [PubMed: 21517797]
89. Kiszewski AE, Bevilacqua M, De Abreu LB. Mesalazine in the treatment of extensive alopecia areata: a new therapeutic option? *Int J Trichology* 2018;10(3):99–102. [PubMed: 30034187]
90. Rashidi T, Mahd AA. Treatment of persistent alopecia areata with sulfasalazine. *Int J Dermatol* 2008;47(8):850–852. [PubMed: 18717871]
91. Bakar O, Gurbuz O. Is there a role for sulfasalazine in the treatment of alopecia areata? *J Am Acad Dermatol* 2007; 57(4):703–706. [PubMed: 17610992]
92. Aleisa A, Lim Y, Gordon S, et al. Response to ustekinumab in three pediatric patients with alopecia areata. *Pediatr Dermatol* 2019;36(1):e44–e45. [PubMed: 30338558]
93. Ortolan LS, Kim SR, Crotts S, et al. IL-12/IL-23 neutralization is ineffective for alopecia areata in mice and humans. *J Allergy Clin Immunol* 2019;144(6):1731–1734. [PubMed: 31470035]
94. Jabbari A, Dai Z, Xing L, et al. Reversal of alopecia areata following treatment with the JAK1/2 inhibitor baricitinib. *EBioMedicine* 2015;2(4):351–355. [PubMed: 26137574]
95. Craiglow BG, King BA. Tofacitinib for the treatment of alopecia areata in preadolescent children. *J Am Acad Dermatol* 2019;80(2):568–570. [PubMed: 30195571]
96. Dai YX, Chen CC. Tofacitinib therapy for children with severe alopecia areata. *J Am Acad Dermatol* 2019;80(4):1164–1166. [PubMed: 30630026]
97. Brown L, Skopit S. An excellent response to tofacitinib in a pediatric alopecia patient: a case report and review. *J Drugs Dermatol* 2018;17(8):914–917. [PubMed: 30124734]
98. Patel NU, Oussedik E, Grammenos A, Pichardo-Geisinger R. A case report highlighting the effective treatment of alopecia universalis with tofacitinib in an adolescent and adult patient. *J Cutan Med Surg* 2018;22(4):439–442. [PubMed: 29463114]
99. Castelo-Soccio L. Experience with oral tofacitinib in 8 adolescent patients with alopecia universalis. *J Am Acad Dermatol* 2017;76(4):754–755. [PubMed: 28325392]
100. Craiglow BG, Liu LY, King BA. Tofacitinib for the treatment of alopecia areata and variants in adolescents. *J Am Acad Dermatol* 2017;76(1):29–32. [PubMed: 27816292]
101. Liu LY, King BA. Ruxolitinib for the treatment of severe alopecia areata. *J Am Acad Dermatol* 2019;80(2):566–568. [PubMed: 30195572]
102. Putterman E, Castelo-Soccio L. Topical 2% tofacitinib for children with alopecia areata, alopecia totalis, and alopecia universalis. *J Am Acad Dermatol* 2018;78(6):1207–1209. [PubMed: 29754888]

103. Bayart CB, DeNiro KL, Brichta L, Craiglow BG, Sidbury R. Topical Janus kinase inhibitors for the treatment of pediatric alopecia areata. *J Am Acad Dermatol* 2017;77(1):167–170. [PubMed: 28619556]
104. Craiglow BG, Tavares D, King BA. Topical ruxolitinib for the treatment of alopecia universalis. *JAMA Dermatol* 2016; 152(4):490–491. [PubMed: 26649829]
105. Fenniche S, Hammami H, Zaouak A. Association of khellin and 308-nm excimer lamp in the treatment of severe alopecia areata in a child. *J Cosmet Laser Ther* 2018;20(3):156–158. [PubMed: 29020475]
106. Al-Mutairi N 308-nm excimer laser for the treatment of alopecia areata in children. *Pediatr Dermatol* 2009;26(5):547–550. [PubMed: 19840308]
107. Al-Mutairi N 308-nm excimer laser for the treatment of alopecia areata. *Dermatol Surg* 2007;33(12):1483–1487. [PubMed: 18076615]
108. Zakaria W, Passeron T, Ostovari N, Lacour JP, Ortonne JP. 308-nm excimer laser therapy in alopecia areata. *J Am Acad Dermatol* 2004;51(5):837–838. [PubMed: 15523373]
109. Jury CS, McHenry P, Burden AD, Lever R, Bilslund D. Narrowband ultraviolet B (UVB) phototherapy in children. *Clin Exp Dermatol* 2006;31(2):196–199. [PubMed: 16487089]
110. Ersoy-Evans S, Altaykan A, Sahin S, Kolemen F. Phototherapy in childhood. *Pediatr Dermatol* 2008;25(6):599–605. [PubMed: 19067863]
111. Yoon TY, Kim YG. Infant alopecia universalis: role of topical PUVA (psoralen ultraviolet A) radiation. *Int J Dermatol* 2005; 44(12):1065–1067. [PubMed: 16409283]
112. Mitchell AJ, Douglass MC. Topical photochemotherapy for alopecia areata. *J Am Acad Dermatol* 1985;12(4):644–649. [PubMed: 3989026]
113. Claudy AL, Gagnaire D. PUVA treatment of alopecia areata. *Arch Dermatol* 1983;119(12):975–978. [PubMed: 6651314]
114. Amer MA, El Garf A. Photochemotherapy and alopecia areata. *Int J Dermatol* 1983;22(4):245–246. [PubMed: 6862752]
115. Lux-Battistelli C. Combination therapy with zinc gluconate and PUVA for alopecia areata totalis: an adjunctive but crucial role of zinc supplementation. *Dermatol Ther* 2015; 28(4):235–238. [PubMed: 25754430]
116. Majumdar B, De A, Ghosh S, et al. “Turban PUVA sol:” A simple, novel, effective, and safe treatment option for advanced and refractory cases of alopecia areata. *Int J Trichology* 2018;10(3):124–128. [PubMed: 30034192]
117. Belezos NK. Local estrogen and ultraviolet irradiation in the treatment of total alopecia (areata). *Dermatologica* 1965; 131(4):304–308. [PubMed: 5865345]
118. Shapiro J Current treatment of alopecia areata. *J Invest Dermatol Symp Proc* 2013;16(1):S42–S44.
119. Lee S, Kim BJ, Lee YB, Lee WS. Hair regrowth outcomes of contact immunotherapy for patients with alopecia areata: a systematic review and meta-analysis. *JAMA Dermatol* 2018; 154(10):1145–1151. [PubMed: 30073292]
120. Singh G, Lavanya M. Topical immunotherapy in alopecia areata. *Int J Trichology* 2010;2(1):36–39. [PubMed: 21188022]
121. Zawar VP, Karad GM. Liquid nitrogen cryotherapy in recalcitrant alopecia areata: a study of 11 patients. *Int J Trichology* 2016;8(1):15–20. [PubMed: 27127370]
122. Stoehr JR, Choi JN, Colavincenzo M, Vanderweil S. Off-label use of topical minoxidil in alopecia: a review. *Am J Clin Dermatol* 2019;20(2):237–250. [PubMed: 30604379]
123. Suchonwanit P, Thammarucha S, Leerunyakul K. Minoxidil and its use in hair disorders: a review. *Drug Des Devel Ther* 2019;13:2777–2786.
124. Price VH. Therapy of alopecia areata: on the cusp and in the future. *J Invest Dermatol Symp Proc* 2003;8(2):207–211.
125. Kumaresan M Intralesional steroids for alopecia areata. *Int J Trichology* 2010;2(1):63–65. [PubMed: 21188031]

126. Coronel-Pérez IM, Rodríguez-Rey EM, Camacho-Martínez FM. Latanoprost in the treatment of eyelash alopecia in alopecia areata universalis. *J Eur Acad Dermatol Venereol* 2010;24(4): 481–485. [PubMed: 20028444]
127. Shreberk-Hassidim R, Ramot Y, Gilula Z, Zlotogorski A. A systematic review of pulse steroid therapy for alopecia areata. *J Am Acad Dermatol* 2016;74(2):372–374. [PubMed: 26775777]
128. Efentaki P, Altenburg A, Haerting J, Zouboulis CC. Medium-dose prednisolone pulse therapy in alopecia areata. *Dermatoendocrinol* 2009;1(6):310–313. [PubMed: 21572877]
129. Phan K, Ramachandran V, Sebaratnam DF. Methotrexate for alopecia areata: a systematic review and meta-analysis. *J Am Acad Dermatol* 2019;80(1):120–127. [PubMed: 30003990]
130. Aghaei S An uncontrolled, open label study of sulfasalazine in severe alopecia areata. *Indian J Dermatol Venereol Leprol* 2008;74(6):611–613. [PubMed: 19171984]
131. Guttman-Yassky E, Ungar B, Noda S, et al. Extensive alopecia areata is reversed by IL-12/IL-23p40 cytokine antagonism. *J Allergy Clin Immunol* 2016;137(1):301–304. [PubMed: 26607705]
132. Gilhar A, Keren A, Paus R. JAK inhibitors and alopecia areata. *Lancet* 2019;393(10169):318–319. [PubMed: 30696569]
133. Accessed October, 2019. <https://www.clinicaltrials.gov>
134. Howell MD, Kuo FI, Smith PA. Targeting the Janus kinase family in autoimmune skin diseases. *Front Immunol* 2019;10:2342. [PubMed: 31649667]
135. Mlacker S, Aldahan AS, Simmons BJ, et al. A review on laser and light-based therapies for alopecia areata. *J Cosmet Laser Ther* 2017;19(2):93–99. [PubMed: 27802065]
136. Messenger AG, McKillop J, Farrant P, McDonagh AJ, Sladden M. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. *Br J Dermatol* 2012;166(5):916–926. [PubMed: 22524397]
137. Goldberg LJ, Castelo-Soccio LA. Alopecia: kids are not just little people. *Clin Dermatol* 2015;33(6):622–630. [PubMed: 26686014]
138. Vivar KL, Kruse L. The impact of pediatric skin disease on self-esteem. *Int J Womens Dermatol* 2018;4(1):27–31. [PubMed: 29872673]

CAPSULE SUMMARY

- Numerous therapies have been used to treat children and adolescents with alopecia areata (AA) with variable efficacy.
- Topical corticosteroids have the highest level of evidence for the treatment of pediatric AA, followed by contact immunotherapy. More clinical trials and comparative studies are needed to further guide management of pediatric AA.

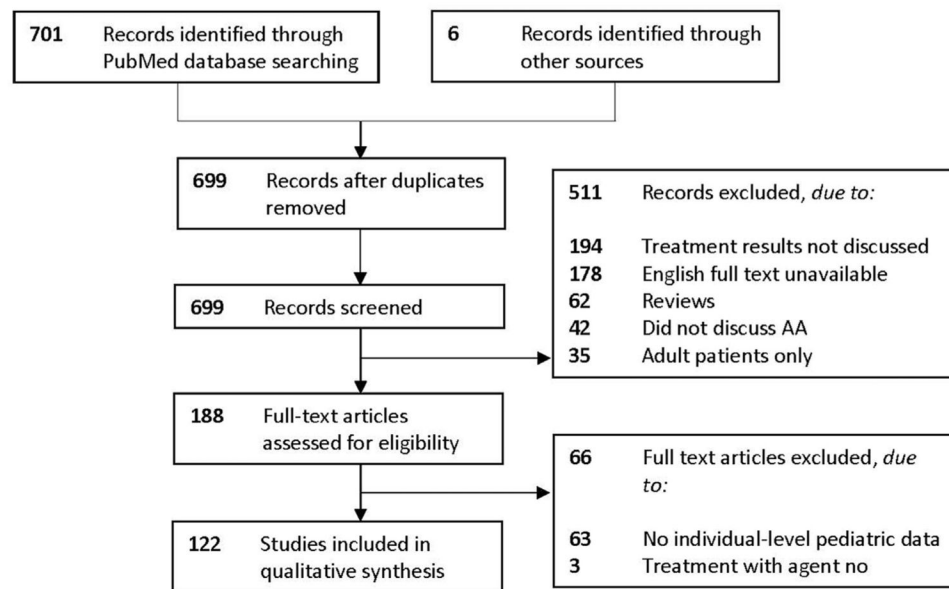


Fig 1. PRISMA 2009 flow diagram illustrating a total of 707 publications retrieved, of which 122 reports were included. AA, Alopecia areata; *PRISMA*, Preferred Reporting Items for Systematic Review and Meta-Analyses.

Included studies evaluating topical and miscellaneous treatment of alopecia areata in pediatric patients

Table 1.

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Anthralin														
Sardana ¹⁹	2018	Anthralin + leflunomide	5	Case report	1	-	-	-	1	1 (100%)	-	-	NA	Itching, burning
Wu ²⁰	2018	Anthralin	4	Case series	37	24	8	3	2	12 (32%)	15 (40%)	5 (14%)	16 (64%)	Irritation, LAD
Ozdemir ²¹	2017	Anthralin	4	Case series	30	27	1	2	-	10 (33.3%)	11 (36.7%)	9 (30%)	2 (9.5%)	Irritation, itching, LAD, hyperpigmentation, crusting, oozing, bullous eruption
Torchia ²²	2015	Anthralin + TC	5	Case report	1	1	-	-	-	-	-	1 (100%)	NA	LAD
Contact														
Immunotherapy														
Wasylyszyn ²³	2016	DPCP + imiquimod vs DPCP	3	Case- control	9	1	3	5	-	Both-2/3 (66.7%) DPCP only-0/6 (0%)	Both-1/3 (33.3%) DPCP only-2/6 (33.3%)	Both-0/3 (0%) DPCP only-4/6 (66.7%)	NA	Scalp eczema, discomfort, LAD
Luk ²⁴	2012	DPCP	4	Case series	3	-	2	1	-	-	-	3 (100%)	NA	Itching, erythema, bulla, scaling, LAD, hyperpigmentation, urticarial reactions
Salsberg ²⁵	2012	DPCP	4	Case series	108	82	-	-	26	12 (11%)	23 (21%)	27 (25%)	NA	Edema, dermatitis, vesicles, desquamation, urticaria, erosions, LAD
Singh ²⁶	2007	DPCP	4	Case series	3	-	-	-	3	1 (33.3%)	2 (66.7%)	-	NA	None
Sotiriadis ²⁷	2006	DPCP	4	Case series	14	7	3	4	-	2 (14.3%)	8 (57.1%)	4 (28.6%)	NA	Eczema, headache, itching, hyperpigmentation
Schutteleers ²⁸	1996	DPCP	4	Case series	25	10	15	-	-	8 (32%)	4 (16%)	13 (52%)	7 (58.3%)	Eczema, itching, vesicles, headache, LAD
Hull ²⁹	1991	DPCP	4	Case series	12	4	8	-	-	4 (33.3%)	4 (33.3%)	4 (33.3%)	4 (50%)	Eczema with superimposed infection, blistering

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Orecchia ³⁰	1985	DPCP	4	Case series	26	9	7	10	-	1 (3.8%)	13 (50%)	12 (46.1%)	4 (28.6%)	LAD, itching, eczema
Chen ³¹	2017	SADBE	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	Angioedema
Guerra ³²	2017	SADBE	5	Case report	1	1	-	-	-	-	1 (100%)	-	1 (100%)	Epidermolysis bullosa acquisita
Tosti ³³	1996	SADBE	4	Case series	33	-	10	23	-	10 (30.3%)	6 (18.2%)	17 (51.5%)	10 (62.5%)	Contact dermatitis, LAD
Orecchia ³⁴	1995	SADBE	4	Case series	28	NA	NA	NA	NA	9 (32.1%)	6 (21.4%)	13 (46.4%)	NA	None
Giannetti ³⁵	1983	SADBE	4	Case series	15	NA	NA	NA	NA	1 (6.6%)	6 (40%)	8 (53.3%)	NA	Eczema, LAD, itching
Cryotherapy														
Jun ³⁶	2017	Cryotherapy	4	Case series	24	NA	NA	NA	NA	5 (20.8%)	15 (62.5%)	4 (16.7%)	NA	Pain, pruritus, inflammation, swelling
Minoxidil														
Rai ³⁷	2017	Minoxidil	5	Case report	1	1	-	-	-	-	-	1 (100%)	NA	Hypertrichosis
Guerouaz ³⁸	2014	Minoxidil	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	Hypertrichosis
Herskovitz ³⁹	2013	Minoxidil	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	Hypertrichosis
Georgala ⁴⁰	2007	Minoxidil	4	Case series	3	2	1	-	-	-	-	3 (100%)	NA	Palpitations, dizziness, sinus tachycardia
Lenane ⁴¹	2005	Minoxidil	4	Case series	1	-	1	-	-	-	-	1 (100%)	NA	None
Baral ⁴²	1989	Minoxidil + TC + ILC	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	Hypertrichosis
Weiss ⁴³	1981	Minoxidil	4	Case series	1	-	-	1	-	-	1 (100%)	-	NA	None
Topical Calcineurin Inhibitors														
Jung ⁴⁴	2017	Topical tacrolimus vs clobetasol, split-scalp	2	Prospective comparative cohort	3	3	-	-	-	TC-2/3 (66.7%) TT-0/3 (0%)	TC-1/3 (33.3%) TT-2/3 (66.7%)	TC-0/3 (0%) TT-1/3 (33.3%)	NA	None
Rigopoulos ⁴⁵	2007	Topical pimecrolimus vs placebo, split-scalp	2	Prospective comparative cohort	1	1	-	-	-	-	-	1 (100%)	NA	Burning

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Price ⁴⁶	2005	Topical tacrolimus	4	Case series	2	2	-	-	-	-	-	2 (100%)	NA	None
Thiers ⁴⁷	2000	Topical tacrolimus	5	Case report	1	1	-	-	-	-	-	1 (100%)	NA	NA
Topical and Intralesional Corticosteroids														
Sankaranarayan ⁴⁸	2017	ILC	5	Case report	1	-	-	-	1	-	1 (100%)	-	1 (100%)	None
Jung ⁴⁴	2017	Clobetasol vs topical tacrolimus, split-scalp	2	Prospective comparative cohort	3	3	-	-	-	TC-2/3 (66.7%) TT-0 (0%)	TC-1/3 (33.3%) TT-2/3 (66.7%)	TC-0/3 (0%) TT-1/3 (33.3%)	NA	None
Lalosevic ^{49#}	2015	Oral PDC + clobetasol	4	Case series	65	35	15	15	26 (40%)	17 (26.2%)	22 (33.8%)	11 (25.6%)	Headache (after oral PDC), skin atrophy	None
Torchia ²²	2015	Triamcinolone + clobetasol vs anthralin, split-scalp	5	Case report	1	1	-	-	-	TC side	-	Anthralin side	NA	None
Lenane ⁵⁰	2014	Clobetasol vs hydrocortisone	1	Randomized controlled trial	41	41	-	-	-	>50% regrowth Clobetasol-17/20 (85%) Hydrocortisone-7/21 (33.3%)	<50% regrowth Clobetasol-3/20 Hydrocortisone-14/21 (66.7%)	NA	Skin atrophy	
Lenane ^{41#}	2005	TC	4	Case series	4	2	2	-	-	2 (50%)	1 (25%)	1 (25%)	1 (50%)	Skin atrophy
Baral ^{42#}	1989	Minoxidil + TC + ILC	5	Case report	1	1	-	-	-	-	-	1 (100%) [#]	NA	Hypertrichosis
Montes ⁵¹	1977	Halcinonide	4	Case series	2	1	1	-	-	2 (100%)	-	-	NA	Folliculitis
Prostaglandins														
Borchert ⁵²	2016	Bimatoprost	1/2	Randomized controlled trial	15	NA	NA	NA	NA	-	Bimatoprost-5/9 (55.6%); Vehicle-1/6 (16.7%)	Bimatoprost-4/9 (44.4%); Vehicle-5/6 (83.3%)	NA	Conjunctival hyperemia, conjunctivitis, eczema, eyelid erythema
Li ⁵³	2016	Bimatoprost (scalp)	5	Case report	1	1	-	-	-	1 (100%)	-	-	NA	None
Zaheri ⁵⁴	2010	Bimatoprost	5	Case report	1	1	-	-	-	1 (100%)	-	-	NA	None
Yadav ⁵⁵	2009	Latanoprost	5	Case report	1	1	-	-	-	1 (100%)	-	-	NA	None

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Mehta ⁵⁶	2003	Latanoprost	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	None

AA, Alopecia areata; AO, alopecia ophiasis; AT, alopecia totalis; AU, alopecia universalis; CR, complete response; DPCP, diphenylcyclopropanone; ILC, intralesional corticosteroids; LAD, lymphadenopathy; LoE, level of evidence; N, number of pediatric patients; NA, not available; NR, no response; OC, oral corticosteroids; PDC, pulse dose corticosteroids; PR, partial response; PT, psychotherapy; RR, relapse rate; SADB, squaric acid dibutylester; SE, side effects; TC, topical corticosteroids; TT, topical tacrolimus.

* Complete response defined as 95% hair regrowth, (n %) = percent of total number of patients.

[†] Partial response defined as 95% and 0% hair regrowth, (n %) = percent of total number of patients.

[‡] No response defined as 0% hair regrowth, (n %) = percent of total number of patients.

[§] Relapse rate defined as number of patients who responded to treatment and experienced recurrence of hair loss, (n %) = percent of responsive patients.

// Patient(s) discontinued study due to adverse events.

[¶] Study listed under both Minoxidil and TC sections as it provides data for both treatments in separate patients.

[#] Study listed under multiple sections due to inclusion of multiple treatments.

Table II.

Included studies evaluating systemic treatment of alopecia areata in pediatric patients

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Intramuscular Corticosteroids														
Seo ⁵⁷	2017	IMC	4	Case series	2	-	2	-	-	1 (50%)	1 (50%)	-	NA	None
Sato-Kawamura ⁵⁸	2002	IMC	4	Case series	1	-	1	-	-	1 (100%)	-	-	NA	None
Michalowski ⁵⁹	1978	IMC	4	Case series	6	-	5	1	-	2 (33.3%)	2 (33.3%)	2 (33.3%)	4 (100%)	Hypertrophic, diabetes, moon facies, striae, dysmenorrhea, pseudoacanthosis nigricans [¶]
Oral Corticosteroids														
Anusret ⁶⁰ #	2016	OC + MTX	4	Case series	4	1	1	2	-	2 (50%)	-	2 (50%) (1 on MTX only)	2 (100%)	Transient elevation of transaminases, weight gain, cataracts, pneumocystis pneumonia [¶]
Gensure ⁶¹	2013	OC + cyclosporine	5	Case report	1	-	1	-	-	1 (100%)	-	-	NA	Confluent and reticulated papillomatosis
Kim ⁶²	2008	OC + cyclosporine	4	Case series	9	5	4	-	-	5 (55.5%)	3 (33.3%)	1 (11.1%)	NA	Edema, acne, weight gain, hypertrophic, GI disturbance, menstrual abnormality
Camacho ⁶³	1999	OC vs ZBC	2	Prospective comparative cohort	18	6	12	3	-	OC-0/9 (0%) ZBC-3/9 (33.3%)	OC-4/9 (44.4%) ZBC-5/9 (55.5%)	OC-5/9 (55.5%) ZBC-1/9 (11.1%)	NA	Cushingoid features, delayed physical development
Alabdulkareem ⁶⁴	1998	OC	4	Case series	11	-	8	1	-	1 (9%)	5 (45.4%)	5 (45.4%)	5 (83.3%)	Acne, striae, moon facies
Schindler ⁶⁵	1987	OC	5	Case report	1	-	-	1	-	1 (100%)	-	-	0 (0%)	Weight gain, Cushingoid features
Unge ⁶⁶	1978	OC	4	Case series	6	1	4	1	-	3 (50%)	3 (50%)	-	3 (50%)	Weight gain
Wintet ⁶⁷	1976	OC	4	Case series	12	3	4	5	-	5 (41.7%)	-	7 (58.3%)	NA	Weight gain, abdominal pain, cataracts, acne, hypertension, seizure, psychological problems, obesity
Pulse Dose Corticosteroids														

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR *	PR †	NR ‡	RR §	SE
Chong ^{68#}	2017	IV PDC + MTX	4	Case series	14	-	14	-	-	1 (7.1%)	5 (35.7%)	8 (57.1%)	NA	Abdominal discomfort
John-Basslet ⁶⁹	2017	IV PDC	4	Case series	13	6	5	2	-	8 (61.5%)	-	5 (38.5%)	3 (37.5%)	Weight gain, acne
Lalosevic ^{49#}	2015	Oral PDC + TC	4	Case series	65	35	15	15	15	26 (40%)	17 (26.2%)	22 (33.8%)	11 (25%)	Headache, skin atrophy
Smith ⁷⁰	2015	IV PDC	4	Case series	18	2	2	3	11	2 (11.1%)	9 (50%)	7 (38.9%)	7 (63.6%)	Mood changes, metallic taste, acne, allergic reaction
Friedland ⁷¹	2013	IV PDC	4	Case series	24	8	4	1	10	9 (37.5%); 5/8 AA, 1/4 AT, 0/2, AU, 3/10 AO	7 (29.2%); 1/8 AA, 1/4 AT, 1/2, AU, 4/10 AO	8 (33.3%); 2/8 AA, 2/4 AT, 3/10 AO	13 (81.2%); 5/6 AA, 1/2 AT, 1/1, AU, 6/7 AO	Verrucae, gastritis, abdominal pain
Droitcourt ^{72#}	2012	IV PDC + MTX	4	Case series	2	2	-	-	-	1 (50%)	1 (50%)	-	2 (100%)	Nausea, neutropenia
Sauerbrey ⁷³	2011	IV PDC + TT	4	Case series	2	-	1	-	-	2 (100%)	-	-	1 (50%)	None
Hubiche ⁷⁴	2008	IV PDC	4	Case series	12	-	4	1	7	-	10 (83.3%)	2 (16.7%)	6 (60%)	None
Sethuraman ⁷⁵	2006	Oral PDC + minoxidil	5	Case report	1	-	-	1	-	-	1 (100%)	-	NA	None
Bin Saif ⁷⁶	2006	Oral PDC	5	Case report	1	-	-	1	-	1 (100%)	-	-	1 (100%)	Nocturnal enuresis
Seiter ⁷⁷	2001	IV PDC	4	Case series	4	2	1	1	-	2 (50%); 2/2 AA, 0/1 AT, 0/1 AU	-	2 (50%)	NA	Headache, fatigue, nausea, palpitations
Sharma ⁷⁸	1999	Oral PDC	4	Case series	4	NA	NA	NA	NA	4 (100%)	-	-	NA	NA
Friedl ⁷⁹	1998	IV PDC	4	Case series	7	1	4	1	1	1 (14.3%); 1/1 AA, 0/4 AT, 0/1 AU, 0/1 AO	2 (28.6%); AA 0/1, AT 1/4, AU 0/1, AO 1/1	4 (57.1%); AA 1/1, 3/4 AT, AU 1/1, AO 0/1	2 (66.7%); AA 0/1, AT 1/1, 1/1 AO	Fatigue, headache, palpitations, dyspnea, nausea
Sharma ⁸⁰	1998	Oral PDC	4	Case series	16	13	3	-	1	6 (37.5%)	6 (37.5%)	3 (18.7%)	4 (33.3%)	Epigastric burning, headache
Kiescl ⁸¹	1997	IV PDC	4	Case series	7	3	1	-	3	5 (71.4%); AA 3/3, AO 2/3	-	2 (28.6%); AT 1/1, AO 1/3	1 (20%)	Abdominal pain
Perriard-Wolfensberger ⁸²	1993	IV PDC	4	Case series	1	1	-	-	-	-	1 (100%)	-	NA	Flushing
Hydroxychloroquine Yun ⁸³	2018	HCQ +/- TC and/or minoxidil	4	Case series	9	6	1	2	-	1 (11.1%)	5 (55.5%)	3 (33.3%)	NA	Headache, abdominal pain, viral gastroenteritis
Methotrexate														

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Mascia ⁸⁴	2019	MTX + azathioprine	4	Case series	3	2	1	-	-	-	3 (100%)	-	NA	GI distress, lymphopenia
Chong ^{68#}	2017	MTX + IV PDC	4	Case series	14	-	14	-	-	1 (7.1%)	5 (35.7%)	8 (57.1%)	NA	Abdominal discomfort
Landis ⁸⁵	2018	MTX	4	Case series	11	NA	NA	NA	NA	4 (36.4%)	7 (63.6%)	-	2 (18.1%)	Leg weakness, tooth sensitivity
Anusief ^{68¶}	2016	MTX + OC	4	Case series	4	1	1	2	-	2 (50%)	-	2 (50%) (1 on MTX only)	2 (100%)	Transient elevation of transaminases, weight gain, cataracts, pneumocystis pneumonia
Batalla ⁸⁶	2016	MTX	4	Case series	3	1	1	-	1	-	2 (66.7%)	1 (33.3%)	1 (50%)	Elevated hepatic transaminases
Lucas ⁸⁷	2016	MTX	4	Case series	13	NA	NA	NA	NA	-	5 (38.5%)	8 (61.5%)	2 (40%)	Recurrent nausea
Droitcourt ^{72#}	2012	MTX + IV PDC	4	Case series	2	2	-	-	-	1 (50%)	-	-	2 (100%)	Nausea, neutropenia
Royer ⁸⁸	2011	MTX +/- OC	4	Case series	14	7	7	-	-	-	11 (78.6%)	3 (21.4%)	3 (27.3%)	Nausea, herpes zoster
Sulfasalazine and Mesalazine														
Kiszewski ⁸⁹	2018	Mesalazine +/- TC, OC, minoxidil	4	Case series	5	3	-	1	1	5 (100%)	-	-	NA	None
Rashidi	2008	Sulfasalazine	4	Case series	7	4	3	-	-	-	7 (100%)	-	NA	Dizziness, headache, dyspepsia
Bakar ⁹¹	2007	Sulfasalazine+ OC	4	Case series	3	3	-	-	-	-	3 (100%)	-	NA	None
Ustekinumab														
Aleisa ⁹²	2019	Ustekinumab	4	Case series	3	2	1	-	-	1 (33.3%)	2 (66.7%)	-	NA	NA
Ortolan ⁹³	2019	Ustekinumab	4	Case series	3	-	3	-	-	-	-	3 (100%)	NA	NA
JAK Inhibitors														
Jabbari ⁹⁴	2015	Baricitinib	5	Case report	1	1	-	-	-	1 (100%)	-	-	NA	None
Craiglow ⁹⁵	2019	Tofacitinib	4	Case series	4	-	1	3	-	2 (50%)	1 (25%)	1 (25%)	NA	None
Dai ⁹⁶	2019	Tofacitinib	4	Case series	3	-	2	1	-	1 (33.3%)	2 (66.7%)	-	NA	Diarrhea, URI
Brown ⁹⁷	2018	Tofacitinib	5	Case report	1	-	-	1	-	1 (100%)	-	-	NA	Headache
Patel ⁹⁸	2018	Tofacitinib	4	Case series	1	-	-	1	-	-	1 (100%)	-	NA	Increased appetite, weight gain
Castelo-Soccio ⁹⁹	2017	Tofacitinib	4	Case series	6	-	-	6	-	-	6 (100%)	-	NA	None

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Craiglow ¹⁰⁰	2017	Tofacitinib	4	Case series	13	6	1	6	-	1 (7.7%)	8 (69.2%)	4 (30.8%)	NA	Headache, URI, transient elevation in hepatic transaminases
Liu ¹⁰¹	2019	Ruxolitinib	4	Case series	1	-	-	1	-	1 (100%)	-	-	NA	URI, weight gain, acne, easy bruising, fatigue [¶]
Puterman ¹⁰²	2018	Topical tofacitinib	4	Case series	11	1	4	6	-	3 (27.3%)	5 (45.4%)	1 (9%)	NA	Irritation
Bayar ¹⁰³	2017	Topical tofacitinib or topical ruxolitinib	4	Case series	6	1	2	3	-	1 (16.7%)	3 (50%)	2 (66.7%)	NA	None
Craiglow ¹⁰⁴	2016	Topical ruxolitinib	5	Case report	1	-	-	1	-	-	1 (100%)	-	NA	Minor decrease in WBC
Laser and Light Therapy														
Fenniche ¹⁰⁵	2018	308 nm excimer lamp + topical khellin	5	Case report	1	-	-	-	1	1 (100%)	-	-	None	Mild transient erythema
Al-Murain ¹⁰⁶	2009	308 nm excimer laser	4	Case series	11	9	2	-	-	5 (45.4%)	3 (27.3%)	3 (27.3%)	4 (50%)	Mild erythema, peeling
Al-Murain ¹⁰⁷	2007	308 nm excimer laser	4	Case series	4	4	-	-	-	-	1 (25%)	3 (75%)	NA	Mild erythema, peeling
Zakaria ¹⁰⁸	2004	308 nm excimer laser	4	Case series	1	1	-	-	-	-	1 (100%)	-	NA	Mild erythema, hyperpigmentation
Phototherapy														
Jury ¹⁰⁹	2006	NB-UVB	4	Case series	6	NA	NA	NA	NA	-	1 (16.7%)	5 (83.3%)	NA	Erythema, blistering, anxiety
Eisoy-Evans ¹¹⁰	2008	PUVA	4	Case series	10	3	4	3	-	2 (20%)	-	-	NA	Erythema, pruritus, burning
Yoon ¹¹¹	2005	PUVA + TT	5	Case report	1	-	-	1	-	1 (100%)	-	-	NA	None
Mitchell ¹¹²	1985	PUVA	4	Case series	5	3	2	-	-	-	5 (100%)	-	3 (75%)	None
Claudy ¹¹³	1983	PUVA	4	Case series	7	2	2	3	-	3 (42.8%)	-	4 (57.1%)	NA	Pruritus
Amer ¹¹⁴	1983	PUVA	4	Case series	2	1	1	-	-	-	-	2 (100%)	NA	None
Lux-Battistelli ¹¹⁵	2015	PUVA + zinc	4	Case series	1	-	1	-	-	-	1 (100%)	-	1 (100%)	Seborrheic dermatitis, acne
Majumdar ¹¹⁶	2018	Topical psoralen + natural sunlight	4	Case series	5	4	-	1	-	-	5 (100%)	-	NA	Erythema, irritation, hyperpigmentation, scaling
Belezos ¹¹⁷	1965	UV irradiation + topical estrogen	4	Case series	1	1	-	-	-	1 (100%)	-	-	NA	None

AA, Alopecia areata; *AO*, alopecia ophiasis; *AT*, alopecia totalis; *AU*, alopecia universalis; *CR*, complete response; *GI*, gastrointestinal; *IMC*, intramuscular corticosteroids; *IV*, intravenous; *LoE*, level of evidence; *MTX*, methotrexate; *N*, number of patients; *NA*, not available; *NBUVB*, narrow-band ultraviolet B; *NR*, no response; *OC*, oral corticosteroids; *PDC*, pulse dose corticosteroids; *PR*, partial response; *PUVa*, psoralen ultraviolet A; *RR*, relapse rate; *SE*, side effects; *TC*, topical corticosteroids; *TT*, topical tacrolimus; *URI*, upper respiratory infection; *UV*, ultraviolet; *WBC*, white blood cells; *ZBC*, zinc biotin, and clobetasol.

* Complete response defined as $\geq 95\%$ hair regrowth, (n %) = percent of total number of patients.

[†] Partial response defined as $< 95\%$ and $> 0\%$ hair regrowth, (n %) = percent of total number of patients.

[‡] No response defined as 0% hair regrowth, (n %) = percent of total number of patients.

[§] Relapse rate defined as number of patients who responded to treatment and experienced recurrence of hair loss, (n %) = percent of responsive patients.

// Adverse events reported in both adult and pediatric patients.

[¶] Patient(s) discontinued study due to adverse events.

[#] Study listed under multiple sections due to inclusion of multiple treatments.

Table III.
Included studies evaluating miscellaneous treatment of alopecia areata in pediatric patients

First author	Year	Treatment	LoE	Study type	N	AA	AT	AU	AO	CR*	PR [†]	NR [‡]	RR [§]	SE
Liu ⁴	2017	Apremilast	4	Case series	1	-	-	1	-	-	-	1 (100%)	NA	Diarrhea, nausea, headaches, lethargy
Cho ⁵	2010	Botulinum Toxin A	4	Case series	3	-	1	2	-	-	-	3 (100%)	NA	None
Sarifakioglu ⁶	2006	Topical sildenafil	4	Case series	8	-	-	-	-	-	3 (37.5%)	5 (62.5%)	NA	None
Fessatou ⁷	2003	Gluten-free diet	4	Case series	2	-	-	-	-	1 (50%)	1 (50%)	-	NA	None
Boonyaveepon ⁸	1999	IVIG	5	Case report	1	-	-	1	-	-	1 (100%)	-	NA	None
Shibuya ⁹	1990	Bone marrow transplant	5	Case report	1	-	1	-	-	1 (100%)	-	-	NA	Chronic GVHD skin eruption
Rozin ¹⁰	2003	Cotrimoxazole	5	Case report	1	1	-	-	-	1 (100%)	-	-	1 (100%)	None
Zawahry ¹¹	1973	Aloe	4	Case series	1	1	-	-	-	-	1 (100%)	-	NA	None
Skurkovich ¹²	2005	Anti-IFN gamma antibodies	4	Case series	16	11	5	-	-	-	12 (75%)	4 (25%)	1 (8.3%)	None
Willemsen ¹³	2006	Hypnosis [¶]	4	Case series	2	-	-	2	-	1 (50%)	-	1 (50%)	1 (100%)	None
Letada ¹⁴	2007	Topical imiquimod	5	Case report	1	-	-	1	-	-	1 (100%)	-	1 (100%)	None
Koblentz ¹⁵	1995	Psychotherapy [#]	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	None
Putt ¹⁶	1994	Massage, relaxation, and reward	5	Case report	1	1	-	-	-	-	1 (100%)	-	NA	None
Teshima ¹⁷	1991	Psychotherapy (PT) + OC and CYA vs OC and CYA	3	Case-control	5	-	-	5	-	PT + OC and CYA - 2/2 (100%); OC and CYA - 1/3 (33.3%)	PT + OC and CYA - 0/2 (0%); OC and CYA - 2/3 (66.7%)	-	NA	None
Atrazola ¹⁸	1985	Topical nitrogen mustard	4	Case series	4	2	2	-	-	-	4 (100%)	-	NA	Allergic contact dermatitis

AA, Alopecia areata; AO, alopecia ophiasis; AT, alopecia totalis; AU, alopecia universalis; CR, complete response; CYA, cyclosporin; DPCP, diphenylcyclopropenone; GVHD, graft-versus-host disease; ILIC, intralesional corticosteroids; IFN, interferon; IVIG, intravenous immunoglobulin; LoE, level of evidence; N, number of pediatric patients; NA, not available; NR, no response; OC, oral corticosteroids; PR, partial response; PT, psychotherapy; RR, relapse rate; SE, side effects.

* Complete response defined as $\geq 95\%$ hair regrowth, (n %) = percent of total number of patients.

[†] Partial response defined as $< 95\%$ and $> 0\%$ hair regrowth, (n %) = percent of total number of patients.

[‡] No response defined as 0% hair regrowth, (n %) = percent of total number of patients.

§ Relapse rate defined as number of patients who responded to treatment and experienced recurrence of hair loss, (n %) = percent of responsive patients.

// Postoperative cyclosporin and short-term methotrexate were also given for graft-versus-host disease prophylaxis.

Both patients were simultaneously treated with selective serotonin reuptake inhibitors.

Psychotherapy was supplemented by minoxidil and anthralin.