Alopecia areata (AA) is an autoimmune disease of the hair and nails. Although genotype alters the risk, the etiology remains unclear. AA typically presents as one or more hairless patches; however, full loss of scalp hair occurs in about 15% of patients (Cranwell et al., 2019; Ikeda, 1965). The relative ease in semiobjectively quantifying the area of bald scalp has resulted in the Severity of Alopecia Tool (SALT) becoming the main measure of disease severity among physicians (Olsen et al., 2004). However, Senna et al. (2022) have substantiated the intimation that the area of AA involvement does not necessarily predict the patients in most need of treatment. The SALT score, for example, does not include eyebrow and eyelash loss, which can result in significant functional impairment, allowing dust and sweat to enter the eyes. This study identifies the key data that connect functional loss to impact on QoL and link self-reported severity with QoL impact while showing that “SALT score alone was insufficient as a proxy for QoL impact.” As such, this translational study shifts the focus from the most objectively measurable outcomes of disease involvement toward the narrative that typically motivates a patient with AA to seek care: the impact on their QoL.

Until recently, AA therapies were infrequently examined in randomized controlled trials, and primary efficacy endpoints were limited to the change in SALT score. However, this study comes at a time when industry-sponsored, randomized controlled trials have led to the licensing of the first disease-specific, systemic immunotherapy for AA in baricitinib by the Food and Drug Administration. Although the emergence of SALT score was not associated with any of the Work Productivity and Activity Impairment.

Redefining Disease severity

The point prevalence of AA is in the order of 1–2 per 1,000 people (Safavi, 1992). In the United States, with a population of almost 330 million, this equates to approximately 329,500–659,000 people. Lifetime risk is estimated at 1.7–2.1% on the basis of long-term United States data (Mirzoyev et al., 2014; Safavi et al., 1995), suggesting that annually, approximately 2 per 10,000 are expected to develop AA for the first time. Globally, this would equate to roughly 1,550,600 new cases a year and with a relatively similar frequency among women as among men (Table 1). With approximately 40% of patients developing a single patch that resolves spontaneously within 6 months (Ikeda, 1965), it is likely that the true incidence and prevalence of AA is underestimated because many of those affected will not have accessed medical care.

The question of reimbursement was recently addressed, speculating a potential cost of £4 billion annually in the United Kingdom alone to treat patients with baricitinib using recent epidemiological evidence of point prevalence and the list cost of baricitinib (Sinclair, 2022). Although this figure assumes that all patients with AA would be treated, it poses the important question of how to define access criteria. Furthermore, focusing solely on the most extensively affected patients by SALT score (alopecia totalis or universalis) would still result in a cost of over £600 million annually.

A recent systematic review and meta-analysis (SRMA) suggests a higher risk of depression and anxiety in patients with AA (Okhovat et al., 2019), whereas a further SRMA identified significant impairment in health-related QoL but with more reliability and validity needed in the instruments used to collect these data. The onset of AA usually occurs before the age of 40, with the 30s representing patients’ most frequently affected decade. Given the social importance of this cohort, at the peak of their working age, there is a considerable need to better assess the unmet need to avoid negatively impacting the dependency ratio in a population. It is therefore interesting that Senna et al. (2022) have shown that SALT score was not associated with any of the Work Productivity and Activity Impairment.

The perfect storm

As such, there is a perfect storm—a prevalent disease, with a potentially marked impact on a cohort of patients at a critical period in their working life. There are emerging therapeutic options, but a disconnect between classic measures that might identify who should have access. This study reiterates.
Clinical Implications

- Costs associated with emerging therapies will require disease severity to be redefined.
- The Severity of Alopecia Tool score was not predictive of life quality.
- Patient-reported outcomes provide a more accurate depiction of diminished life quality.

the need to include eyebrow and eyelash compound measures of AA severity. There is also a call for change in clinical practice, by encouraging the recording of either patient perception of disease activity (mild, moderate, or severe) or, as favored by the authors, the Patient Global Impression of Severity scale. The latter, as noted by Senna et al. (2022), is a validated scale recommended for incorporation in research and clinical settings. These would also be useful to include in patient registries, such as the Global Registry of Alopecia Areata Disease Severity and Treatment Safety (Wall et al., 2021)

At a crossroads in the story of AA, where the journey ahead now offers promise rather than bleak uncertainty, Senna et al. (2022) have, in this paper, created signposts toward a more patient-centric means of characterizing disease severity.

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CONFLICT OF INTEREST

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REFERENCES


Table 1. The Estimated Prevalence of AA and Associated Costs of Baricitinib Treatment According to List Price for Selected Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Population (Millions)</th>
<th>Estimated AA Populationa</th>
<th>Estimated New AA Diagnoses Per Yearb</th>
<th>Estimated Cost of Baricitinib Treatment for all AA Per Yearc ($ Millions)</th>
<th>Estimated Cost of Baricitinib Treatment for AT/AU Per Yeard ($ Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>7.753</td>
<td>7,753,000–15,506,000</td>
<td>1,550,600</td>
<td>471,112</td>
<td>70,666</td>
</tr>
<tr>
<td>Europe</td>
<td>746.3</td>
<td>746,300–1,492,600</td>
<td>149,260</td>
<td>45,349</td>
<td>6,802</td>
</tr>
<tr>
<td>United States</td>
<td>329.5</td>
<td>329,500–659,000</td>
<td>65,900</td>
<td>20,022</td>
<td>3,003</td>
</tr>
<tr>
<td>Australia</td>
<td>25.7</td>
<td>25,700–51,400</td>
<td>5,140</td>
<td>1,561</td>
<td>234.2</td>
</tr>
<tr>
<td>South Africa</td>
<td>59.3</td>
<td>59,300–118,600</td>
<td>11,860</td>
<td>3,603</td>
<td>540.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>67.2</td>
<td>67,200–134,400</td>
<td>13,440</td>
<td>4,083</td>
<td>612.5</td>
</tr>
<tr>
<td>Ireland</td>
<td>5.1</td>
<td>5,100–10,200</td>
<td>1,020</td>
<td>309.9</td>
<td>46.5</td>
</tr>
</tbody>
</table>

Abbreviations: AA, alopecia areata; AT, alopecia totalis; AU, alopecia universalis.

a Based on an estimated point prevalence of 0.1–0.2% (Safavi, 1992)

b Based on an estimated lifetime risk of 1.7–2.1% (0.02% per year) (Mirzoyev et al., 2014; Safavi et al., 1993)

c Based on the list price of baricitinib ($2,497.20 per 30 days) if all estimated patients with AA were treated (Sinclair, 2009)

d Based on an estimated prevalence of total scalp loss of 15% of all patients with AA (Cranwell et al., 2019; Ikeda, 1965).