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Case Report

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Trichotillomania First Time Diagnose in Pregnancy: A Case Report

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Abstract

A 34-year-old pregnant woman with a gestational age of 22 weeks. She presented to the primary health care center with complaints of excessive anxiety and pulling out scalp hair since she got pregnant and found difficulty controlling the urge for hair pulling. On examination: Frontal scalp hair loss with broken and short hair. After an initial assessment, the patient was diagnosed with trichotillomania according to the diagnostic criteria of the DSM-5. We started the treatment with behavioral therapy and were referred to psychiatry.

Keywords: Trichotillomania (TTM); Obsessive-compulsive disorder (OCD); Disorders, Fifth Edition (DSM-5).

Introduction

Trichotillomania (TTM) is a de novo illness that was initially identified by Holopeau in 1889. It is typified by an overwhelming desire to pluck out one's hair [1]. And the illness is often persistent and chronic [2, 3]. It's a common disease in pediatrics and adolescents and rarely starts in pregnant patients [1].

Case

Here we discuss a case about a pregnant patient with new-onset trichotillomania that started during pregnancy although patient's past history was not remarkable for such a condition.

In June 2022, a 34-year-old pregnant woman with a gestational age of 22 weeks G4P3+0, previous uneventful spontaneous vaginal deliveries, irregular prenatal care appointments. She presented to the primary health care center with complaints of excessive anxiety and pulling out scalp hair since she got pregnant and found difficulty controlling the urge for hair pulling. She felt less stress from the pulling behavior. The patient reported that when she woke up early in the morning, she found a lot of hair in the bed. She pulled out her hair almost every day, intermittently throughout the day.

The patient denies depression, psychotic symptoms, mania symptoms, or other symptoms of obsessive-compulsive disorder. No sleep problem, no suicidal attempt or plan, No history of previous psychiatric disease, No history of previous perinatal or postpartum psychiatric disease No family history of psychiatric disease; normal childhood life.

On examination:

Vital signs: BP 108/60, HR 80, RR 20, Temperature 36.5.

A general examination showed:

Frontal scalp hair loss with broken and short hair.

Obstetric examination:

Abdomen: soft, lax, No tenderness, Positive fetal cardiac activity.

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Psychiatry assessment:

The patient looked her age.

Looks well, alert and oriented. The self-care was moderate, with good eye contact. Her spontaneous and voluntary attention, concentration, memory, and perception were within normal. No psychosis were present. The patient had normal judgment and insight.

After an initial assessment, the patient was diagnosed with trichotillomania according to the diagnostic criteria of the DSM-5. We started the treatment with behavioral therapy and were referred to psychiatry.

Discussion

Trichotillomania is classified as an obsessive-compulsive disorder (OCD) by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The disorder is characterized by recurrent body-focused repetitive behavior (hair pulling) and repeated attempts to reduce or stop the behavior. Hair pulling can happen in both calm and stressful situations, but before the habit starts or when an effort is made to stop it, tension frequently builds [4, 5].

TTM most usually affects the scalp, though it can also affect the lashes, brow, pubic, face, and extremities hair [6]. Pregnancy and the postpartum period are prime times for the development or aggravation of obsessive-compulsive disorder (OCD) symptoms, which can be extremely distressing and incapacitating [7]. Prior research examines the frequency of all clinically relevant symptoms associated with obsessive-compulsive disorders and related disorders during pregnancy and the postpartum phase (OCRD; e.g., excoriation disorder (ED), trichotillomania (TTM), body dysmorphic disorder (BDD), and hoarding disorder (HD). The most common symptoms were those of OCD and BDD. 6.2% (N = 17) of participants supported clinically significant OCD symptoms during pregnancy, while 14.9% (N = 41) of participants endorsed clinically significant BDD symptoms [7]. Furthermore, it was discovered that elevated OCRD symptoms are linked to worse postpartum functioning in all domains. Future studies should examine the potential effects of all OCRD symptoms, not just OCD symptoms, on functioning during the perinatal period [7]. A case study by Z. Studziński the authors of this case study describe a 23-year-old lady who had a trichobezoar discovered in her stomach and removed after a cesarean delivery. Through anamnesis, we discovered that the woman had trichophagia and trichotillomania since she was a little child. The hair and nail fragments that were constantly eaten formed a massive trichobezoar that almost filled the stomach [8]. The lack of FDA-approved medications for TTM makes it challenging for clinicians to choose a suitable treatment strategy at this time. Which drug classes should be provided is not sufficiently or consistently supported by the clinical investigations that have been conducted. TTM's etiology is yet unknown [9].

Conclusion

Trichotillomania is a rare psychiatric disorder commonly diagnosed in children and adolescents, and its new onset in pregnancy is not common to the best of our knowledge. The psychoetiology in pregnant people might be due to hormonal changes during pregnancy.

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