National
Alopecia Areata
Foundation®

Mild, moderate, and severe alopecia areata: Understanding severity and treatment choices
Dr. Brett King – Feb. 19, 2026

LISA ANDERSON, PHD: (00:33)
Okay, let's get going. Welcome to the National Alopecia Areata Foundation's webinar, Mild, Moderate and Severe Alopecia Areata, Understanding Severity and Treatment Choices. Joining us today is Dr. Brett King. And I'm Lisa Anderson, Vice President of Research and Education for NAAF.

Before we start the webinar, I'd like to cover a few housekeeping details. We have disabled chat for this webinar session. Please post your questions for Dr. King in the Q &A section. Please keep in mind that your, please keep your questions as general as possible for the benefit of all audience members. This webinar is being recorded and all registrants will receive a link to the recording by email. And finally, please share your feedback with us. At the conclusion of the webinar, a link to a short survey will pop up in your browser window.

Please complete the survey there. We will use your input to plan future webinars. Note that live captioning is available for this webinar. To turn on the captions, click the CC slash show captions button on the Zoom toolbar. Captions will appear automatically at the bottom of your screen.

This webinar is part of NAAF's You Are Not Alone education and empowerment webinar series. NAAF gratefully acknowledges the support provided for this webinar series by our partners, Lilly, Pfizer, and Sun Pharma.

Before we get started, I'd like to tell you a bit about NAAF and our mission. The National Alopecia Areata Foundation is the leading advocacy organization for alopecia areata. NAAF's mission is to drive research to find a cure and accessible treatments for alopecia areata, support those impacted, and educate the public about the disease. NAAF's vision is an empowered community with a choice to embrace or live free of alopecia areata. To learn more about NAAF's support resources and research and advocacy activities, or to join us as an advocate or supporter, please visit our website at naaf.org.

We know that it can be confusing to hear all the terms used to talk about alopecia areata, patchy, diffuse, ophiocis, totalis, universalis, mild, moderate, and severe. The NAAF team wants you to know that even though there are many words used, they all refer to one disease, the autoimmune disease, alopecia areata, and that's what we're here to talk about with Dr. King today. And now on to today's webinar, mild, moderate, and severe alopecia areata, understanding severity and treatment choices.

It's always a pleasure to have Dr. King join us on our webinar series. As you may already know, Dr. King pioneered the use of JAK inhibitors in dermatology as the first dermatologist to show that they were effective for the treatment of alopecia areata, vitiligo, eczema, and other diseases. He has also advanced the use of oral minoxidil for treatment of male and female pattern hair loss and other forms of hair loss.

After completing his medical training, Dr. King spent 14 years on the full-time faculty at the Yale School of Medicine before recently transitioning to private practice in order to focus on patient care, clinical research, and medical education. He's been an investigator in numerous clinical trials, including those leading to FDA approval of Olumiant Litfulo and Leqselvi for the treatment of alopecia areata. Dr. King was named an American Academy of Dermatology Patient Care Hero for his work treating patients with severe alopecia areata. We're very fortunate to have him as a member of NAAF's Board of Directors and Research Advisory Council. Dr. King, thanks so much for being here today, and I'm gonna stop sharing and I will turn it over to you.

BRETT KING, MD, PHD: (04:08)
Great. Thank you so much, Lisa, for the kind introduction. And it's really a pleasure to be here with all of you. This is, I guess, maybe my third or fourth time doing one of the NAAF webinars. And I really believe in these. think the alopecia areata community is deeply informed about alopecia areata and really so much about it, including why it happens and how to make it better. I think very often many of you show up to visit with a dermatologist knowing more about the condition and its treatment or treatment options than even the person that you are seeing. so it's really, for me, it's one of the things that I really love about being a part of this community. Again, it's just the the kind of the hunger for information. And I really believe that these NAAF webinars really elevate knowledge in the community, which will ultimately elevate the care of everyone who is dealing with this condition or their family members. Because without knowledge, we're going to really struggle as a community to get further. And so I really applaud NAAF ~ for hosting these webinars. I applaud the companies that support them because otherwise you're really stuck with five minutes of information that you're going to get in a doctor's visit or a whole bunch of information of variable quality on the internet. so again, with that, again, I'm grateful to be here. I'm grateful that you're all here. And we're going to talk about, I think a really important topic. And that is, what is, when you show up to somebody's office.

How are they going to look at your spot or your spots or your amount of hair loss and think about you in those terms. Is this somebody with a little bit of alopecia areata? Is this somebody with a lot? How is it affecting you? And ultimately, hopefully, assembling all of that information into a...treatment plan. And so that's what we're here to talk about. We're not going to go deep into the results of treatments with one thing or another. I'm only going to present treatments for which there is high quality data to support its use, but we're going to talk more about how does anybody arrive at using a shot in the scalp versus an oral medicine.

So here are, right, not everybody is gonna look at this screen and say, that's me. But hopefully, hopefully most everybody will say, that, you know, if I, you know, I look like that image or I look like that image plus the eyebrows or the eyelashes or the fingernails. So again, kind of the...representation of the spectrum of alopecia areata, a spot or a few spots, somebody here with numerous spots. This is somebody whose alopecia areata is sort of localized to the lower half of the back of the scalp. And then you can see it rising up over the ears. This is somebody who the entirety of the top of their head Just the top of their scalp is involved, but not the sides. Here's somebody with complete loss. And then over here, again, images of people who have eyebrows involvement, eyebrows and eyelashes involvement. Here's somebody with just upper eyelid or upper eyelashes, but not eyebrows and not lower eyelashes, beard involvement, and then nails.

And Lisa already sort of presented this, but I just want to visit this again. This is at the start of every one of my presentations. Whether I'm here talking with all of you, or I'm talking to my dermatology colleagues, I think it's really important that we have a common language.

If we don't have a common language, then we're going to struggle to communicate effectively. And so the point I want to make here is that all of the people, all of the images here are of alopecia areata, but of slightly different presentations. Again, this is a person with a spot. This person with a spot, just to be clear, was also this person. This is the back of his head. This was his chin.

This is somebody who again has patchy alopecia areata, but is very different, right? This is many, many, many patches. This is that person with involvement of the back of their scalp kind of rising up over their ears. We call that ophiocis alopecia areata. This person whose involvement is literally the top the entire top in a male, this might be confused sometimes with male pattern hair loss. This is somebody who has very diffuse, so no spots, but alopecia areata over the entire surface of their scalp. And then this is somebody who has complete scalp hair loss.

And that is sometimes called alopecia totalis when you have complete scalp hair loss and also no eyebrows, no eyelashes, no facial hair, no body hair. Then we call that alopecia universalis. My point here is it's all alopecia areata. And we're going to talk about how we think about these different presentations in terms of an idea of mild or moderate or severe alopecia areata. But again, this person with alopecia totalis or alopecia universalis still has alopecia areata. It's just severe alopecia areata.

So again, it's all alopecia areata. do you think that this is, it's an important point because sometimes, know, somebody, it'll be the initial consultation. They just came to see me for the first time. We get 10 minutes or 20 minutes or 30 minutes into a visit and they say, you know, excuse me, but I don't have alopecia areata. I have alopecia totalis. ~ nope. That's okay.

It's all alopecia areata.

Okay, so now here, we as dermatologists in general in medicine, we think about disease severity when we think about treatment, right? We don't rush to give a pill that might have side effects or might have many side effects

to somebody with a spot.

And similarly, when somebody has no hair, we're not going to reach for shots into the scalp. And so it's helpful for us to think about, well, what's mild and what are the treatments that we're going to use for mild alopecia areata? How do we think about severe? And once we have an idea for what severe is, then...

Well, what are the treatments that we're going to bring to bear for that person? And then that person in the middle with moderate alopecia areata, what is that? And then what's an appropriate treatment or treatments for that person, which might again be different than the person with mild or the person with severe.

So let's start with scalp hair loss, right? And this is kind of the anchor, if you will, for considerations of mild, moderate, or severe alopecia areata because it's the most common site of hair loss involvement in alopecia areata. So when we think about scalp hair loss,

Let's take these four different people, somebody with a spot, somebody with many spots, right? And you can imagine all of these spots, this person's spots are not just on the left side of their scalp, right? They're moving over to the other side as well. Again, this person, the entire top of their scalp is involved. And then this person whose entire scalp has no hair.

So how do we assess each of these people? We're going to use what's called the SALT score. And the SALT score is nothing more than an assessment of the amount of scalp hair loss. So let's think about the extremes. A SALT score of zero is 0 % or no scalp hair loss.

At the other end, we have a SALT score of 100 or 100 % scalpar loss or complete scalpar loss. And then of course, there's a SALT in the middle. You have a SALT score 50 or 50 % scalpar loss. And obviously, right, you can be anywhere in between zero and 100. So.

If we think about these four people, this person, again, roughly, and we're going to look at more, we're going to look at additional images shortly. But again, I think you get this idea that this person with a sort of a silver dollar sized spot here, their SALT score is about three or 3 % scalp hair loss.

This person with so many spots over the entire scalp has about 30 % scalp hair loss or a SALT score of 30. This person, again, whose entire top is missing and then a little bit on the sides, but not much, 50 % scalp hair loss. And then this person here with no scalp hair is a SALT score of 100 or 100 % scalp hair loss. So now,

This is our tool. This is how we're going to think about scalp, the assessment of scalp hair loss.

But we now need to put these different amounts of scalp hair loss into different buckets or different categories. So here in the top is really this is the scale that has really led to so much of the way we now think about mild, moderate, and severe. And what this scale says, and by the way, this scale was developed largely with people living with alopecia areata and a handful of alopecia areata dermatologists. So just to be clear, I think that that's an important bit of background. There probably many most people don't know, this was actually developed in coordination with people living with alopecia areata And what it says is that mild alopecia areata might be sort of that one to 20 % scalp hair loss. And again, we're gonna see images of what that looks like. Moderate. might be somebody around greater than mild, less than severe. So in this scale, somewhere between 20 and 50 % scalp hair loss is moderate. And then severe and very severe, they kind of, we put them together. And the idea is that that somebody with 50 to 100 % scalp hair loss.

And so now for anybody on the webinar who has read about, learned about, saw a dermatologist and heard about JAK inhibitors for alopecia areata.

The idea is that all JAK inhibitors to date are FDA approved for severe, literally the word is severe alopecia areata. That word severe comes directly from this scale. And that is because this scale was developed at the start of clinical trials of oral JAK inhibitors in alopecia areata and to date clinical trials in alopecia areata of these oral medicines have been in people with 50 % to 100 % scalp hair loss. And therefore, when the FDA looked at the clinical trial data and said, okay, yep, these medicines are often effective. in these people, they didn't want to say, JAK inhibitors are approved for people with 50 to 100 % scalp hair loss, but rather give it sort of an easy to use term, and that's severe. And again, that severe comes exactly from this scale. Okay. So let's just think about, take a few examples. of different amounts of scalp hair loss and what they look like.

So here, this is somebody with a SALT score of 100 or 100 % scalp hair loss. Now, many of you paying close attention are gonna look at the screen and say, but I see when I look across the top kind of side lighting on this person's scalp, I see little tiny hair, many little tiny hairs. Nobody's goal is to grow what we call vellus hairs or those baby hairs. Our goal when we regrow hair is to grow real hair, that sort of thing of as kind of a thick bristly hair that grows long, vellus hairs never grow long. And so the reason I say this person has a SALT score of 100 or this person has no scalp hair, it is because they have no, again, terminal thick caliber hairs. like we want to grow.

So this is severe. Again, just to jump back here, we jump back to the scale, 50 to 100 % loss is severe. Again, we're gonna put severe and very severe together in the same bucket. So again, this person has severe alopecia areata.

Now this person here has a SALT score of 18 or 18 % scalp hair loss. So you can see here, right? The back is fully grown. The top is nearly fully grown. There might be a little spot right there. And even the sides are largely...regrown, but not completely, right? There's hair missing here on the left and there's hair missing here on the right. And so this person has about 18 % scalp hair loss. And so again, 18 % or a SALT score of 18, we go, sorry. This person has mild alopecia aerata. Why do we call it mild?

Again, we go back to the scale and 1 to 20 percent is limited or mild.

So that's why, again, we would say, ~ mild about mild. And we're gonna keep developing this idea as time goes by. But again, this is sort of where I want everybody to begin to think about severity. So now here, this person for sure has those, right, those thick hairs, like is the goal of treatment.

But for sure, not enough, right? The vast majority of the scalp is missing those hairs. And so this person has maybe about 15 % of their hair, which means about 85 % is missing. So that's a SALT score of 85, which again, going back to that scale would be severe.

And then here.

This person, back of their head, it's all there. It's mostly here on the left side. The top is largely there, but there's this patch here missing. And then on this person's right side, there's hair there, but there's a big spot missing. And so this is somebody with a SALT score of about 27.

And again, it's not, I would never say like, oh, this is 27 and it's only 27. No, maybe it's 25, maybe it's 30, maybe it's 32. But the idea is that we're in that range. And again, using that scale, that's moderate, alopecia areata.

And so we have now this idea of mild, moderate and severe thinking about scalp hair loss only.

But we all know, everybody on this call knows, alopecia areata is not just scalp hair loss, right? We saw in those sort of introductory, that introductory slide, eyebrows can be involved, eyelashes can be involved, facial hair can be involved, body hair can be involved. And so it's not appropriate to just think about it in terms of scalp hair loss.

It's not one dimensional. This is a multi-dimensional issue. And eyebrows involvement can be hugely important. Beard involvement can be hugely important. So.

Considering all of that a group of us got together a few years ago and we devised this more complete concept of alopecia areata severity. So the idea here is that we're going to think about scalp hair loss, right? You see in the very top of this mild, moderate and severe.

And these are the same numbers that we were just looking at in that other scale, less than 20 % loss. 20 % 50 % loss is moderate. 50 to 100 % is severe. But what about these other important parts of alopecia areata? What about eyebrows or eyelashes involvement? What about people who have two or three spots, but they don't respond to treatment. Well, we should be thinking about that when we think about severity. What about the person who comes in with three quarter-sized spots, but they tell us every day there is a big knot of hair in the shower drain.

Every day I wake up, and my pillowcase is covered in hair. Well, that person is rapidly losing their hair everywhere. They might only have a few spots, but they're rapidly losing hair everywhere. Well, we should consider that when we think about severity. And then lastly, this fourth bullet, what about the people who have a few spots or more spots? but it's taking a profound toll on their psychological wellbeing, their emotional health. They're starting to make big decisions around their hair loss. Relationships become a struggle. A child doesn't wanna go to school. You're having a hard time going to work. We should consider that in severity. It might only be a few spots.

But it's taking a huge or has a huge burden. And so we should consider that. And so what this alopecia areata scale or the AASC, A-A-S-C, does is it says, we're gonna start up here with amount of scalp hair loss, but then we are going to take account of these other important features. So just a couple of examples to help make the point.

So again, let's take this person a spot or two for sure, right? 3 % scalp hair loss or less, maybe 5%. So mild, but...

this person is missing eyebrows or has eyebrow involvement. It doesn't have to be like they're both gone. Well, that's not mild. And so this person with mild scalp hair loss becomes someone we think of as having moderate alopecia areata.

What about this person? It's not more than half of their scalp. It's about 30%. But this person is withdrawing from the world because of their hair loss, right? This person has a hard time getting up every day, going to work, doing the things that they're supposed to do. And so it's not moderate. It's severe. And by the way here, you know, this scale, right, we could also say that this person, that it's severe. But what I want to kind of illustrate or present to all of you is that, right, if in medicine we sort of, we present publicly, we put in the medical literature a scale that permits, in a sense, permits everybody to be severe, what happens when
healthcare systems or insurance companies come and say, how are we going to allocate resources for expensive medicines? If you as a community of dermatologists say that everybody, everybody's severe, well, then we're not going to listen to you anymore. So we have to have credibility. In order to have credibility, we have to have a little bit of nuance about mild, moderate and severe.

But again, anybody who would say, but you know, three spots on my scalp, they're in the wrong place and an eyebrow, well, right, for sure that can be severe for that person. And I would never argue and say, no, it's not. Yeah, no, the scale says it's moderate. But again, this is just an idea to help us kind of advance treatment and advance the way we think as a community about different people with different alopecia areata. So again, coming back here to one of that, you know, our early slides, we often think about disease severity when considering treatment. So we're gonna create these categories of mild, moderate and severe alopecia areata. We just describe different ways of thinking about mild, moderate and severe. And then with that, we're going to create a treatment algorithm.

And this I would say is a very contemporary, this is by the way, this is my treatment algorithm. There's not like one treatment algorithm that all dermatologists or all experts agree on. But I think this is largely what my colleagues, anybody who thinks a lot about this would agree with. And that is again, this person with a spot or a few spots and really nothing else. No eyebrow bubble, no eyelash involvement. It's not really bothering them. It's not rapidly evolving. In a way, sort of the most common presentation of alopecia areata. Well, appropriate for treatment are shots, assuming somebody tolerates them.

Again, the treatment should never be worse than the disease. And if shots don't work after three or four times getting them, well, then it's time to move on. But the idea is that we have a lot of data that that shots work for limited or mild alopecia areata. Other things that we...not uncommonly do topical steroids, sometimes with topical minoxidil. There's not a whole lot of data to support topical minoxidil, but it's easy and it's easy to add to topical steroids. Topical irritants are appropriate in this category. Why do I think they're really only appropriate for mild? And by the way, I don't myself use them much, but why do I think that they're appropriate for mild, but not for moderate or severe?

They're irritants, right? They cause redness. They cause itchiness. We don't want to do that except to a small, relatively small area of the scalp. Now, if we could construct one of these without the irritation, well then maybe we would think about it for somebody with moderate scalp hair loss. And then oral minoxidil.

Oral minoxidil, I think, is absolutely appropriate in every category of alopecia areata. And there's data for it. Again, I just want to be clear. There's data for everything here. And we're not going to go into the data because that's relatively unimportant. But there's data to support each of these boxes.

It doesn't mean that, again, the shots always work for somebody with a spot or two. It doesn't mean that oral minoxidil always works for somebody with a spot or many spots or no hair loss, but there's data to support that it works often enough that it belongs in that box. It belongs in a place where if you were to walk into a dermatologist's office and that person were to say to you, you know, gosh, you know, the shots work for you.

But every three months, you have another spot. Well, that kind of persistence, the constant activity in my mind says, geez, we should try to do something from the inside out. And oral minoxidil would be a good place for that. Moderate, so now here, oral minoxidil, oral steroids. So think prednisone, other systemic immunomodulatory medicines. So, methotrexate might be something that you've heard about. Cyclosporine might be something you've heard about. To be perfectly clear, there's not a ton of data to support that these are, you know, absolutely the right thing in this category, but there is enough data that it's not unreasonable if somebody were to, you know, your dermatologist were to say, well, this is where we're going to start. It would never be okay, you know, if after six months of taking methotrexate, you're not growing your hair, well, then it's time. It's time to reconsider treatment and look at something else in this box. Or using the alopecia areata scale,

Right? There was moderate alopecia ureata by amount of scalp hair loss, meaning 30%. But remember, one of those other features was treatments not working over six months. So using the alopecia ureata scale, you now, in my mind and in the mind of those of us who develop that scale, which is being quite widely adopted around the world, right, that person...while their amount of scalp hair loss may be moderate, but they're now severe, which now moves you from treatment in this box to treatment over here. I hope that people kind of see why that alopecia on a scale can be so useful. And then the last item in this moderate category, JAK inhibitors.

We have a lot of data emerging that JAK inhibitors are effective, but, but, remember when a medicine is approved, it gets approved for in some sense, a category of disease. JAK inhibitors were approved for the category severe.

where severe again came from that very first scale. I showed you two scales, but that very first scale took account only of scalp hair loss. 50 to 100 % was severe and therefore, JAK inhibitors you see over here on the far right, severe alopecia areata, we see. And this, I really hope, I'm afraid it's not always true.

But I really hope that we are, as a community of dermatologists and doctors, advancing this idea that, really, for severe alopecia areata, everybody should be offered or considered treatment with Litfulo, Olumiant, or Leqselvi. And then again, this is sort of my own kind of thought about treatment. I almost always use oral minoxidil in addition to a JAK inhibitor. And then sometimes we'll reach for to Dupixent in particular in patients who also have atopic AD is atopic dermatitis, which is our word for eczema. so again, severe, but Litfulo

Olumiant like Leqselvi with or without oral minoxidil. We might think about Dupixent. And just to be clear, we have some more slides, but just to be clear before we move on, what's really interesting, and again, for all of us to know, is that the only medicines for which there is really high quality data, meaning clinical trials where some people get nothing, some people get medicine, we watch them for six months or nine months to see how well medicine works. The only things for which there's that kind of high-quality data, or evidence, are Litfulo Olumiant and Leqselvi right now. And there are other things in clinical trials. We'll finish up with those things. But everything else on this list is really sort of...

Again, this is my algorithm based on my interpretation of the data. think that for those of us who think a lot about this, there would be agreement with my algorithm. Okay, so now we're getting close to the end and time for Q &A. So again, let's just go back to this sort of the many different ways that alopecia areata presents many different ways it can look.

We have this scale. And this is really the scale that I would advocate that we should be using. And that I want my colleagues in dermatology to think about when somebody comes into their office with alopecia areata.

The alopecia areata scale on And so let's just think about again this person.

Well, this person...has, right, if that's all they have is that spot, they're not particularly bothered, there's not eyebrow involvement, they're not rapidly shedding, well, then this person has mild alopecia areata. So then we go to the treatment algorithm. So now I'm trying to marry all of the parts of this talk. So now we come here and we say, well, what's most appropriate for this person? As long as they don't mind three or four or six needle pokes, shots are absolutely appropriate. If they say, no, not interested in a shot, well then a topical steroid plus topical minoxidil is fine. A topical irritant would be fine. Oral minoxidil would be fine.

So now this person here in the lower left-hand corner.

It's a lot of hair loss. And arguably, once you get to this much hair loss, it's severe. But again, trying to have a more nuanced view to help us have credibility as a profession, where we say, well, okay, well, this isn't this, but it's a lot more than this. And so we come here to the alopecia areata scale. We say, this person has about...

30 % scalp hair loss, well, that's moderate. But again, right, we already did this with the scale, right? This person also has negative impact on psychosocial functioning, right? They're withdrawing from the world. Or we treat them for six months with methotrexate or steroids and they don't get better. Well, then this person no longer has moderate, they have severe.

And so we're going to come over here. But remember though, this person, they're like, ~ doctor, it doesn't bother me too much. And again, there's no eyebrows, no other involvement. then you can reasonably put this person in this category of moderate. And then you come here to the treatment algorithm and you say, well, okay, let's see, what are our options in this category? Oral minoxidil, not a bad idea. Oral steroids, not a bad idea. Methotrexate or cyclosporine, not a bad idea. JAK inhibitors, for me personally, absolutely, but I'm not everybody. I'm not all dermatologists. And so, again,

You know, this algorithm has to kind of give everybody the ability to sort of bring their own sense of what the totality of the data says and say, well, no, this person, you know, in my experience, I think that the literature says that this person might succeed with methotrexate. Again, where I would quarrel with that person is if after six months of methotrexate, they're not better.

Well, then it's time to move on. This person no longer has moderate alopecia areata. They have severe alopecia areata and we should be graduating to oral JAK inhibitors

And this is my last slide, just here to kind of highlight sort of how amazing all of this is.

It was 11 years ago, almost 12 years ago, that I published that very first person Kyle, who successfully re-grew his hair with Xeljanz And at that time there was nothing. And even Xeljanz right, I was reaching, I was reaching and borrowing that medicine from rheumatology.

Alopecia areata was on nobody's radar. NAAF had been helping already to advance our understanding of disease, supporting the science that ultimately kind of revealed the pathways that we should be chasing to try to make disease better. And now here, almost 12 years, not even 12 years later, we have three approved medicines.

Upadicitinib which has the brand name Rinvoq presently approved for eczema and seven other conditions, rheumatoid arthritis, juvenile arthritis, Crohn's disease, ulcerative colitis. I'm hopeful that Rinvoq will be approved for alopecia areata in the next year. That will be four medicines. And then there are these things that are in development.

There's so much happening. And then here, with topicals, there are even other things, sort of non-systemic medicines that are being developed. so the idea is like, we've come so far in so short a time, it's extraordinary that we have three, hopefully four medicines approved soon.

We really are excited about the possibility of having non-JAK inhibitors approved in alopecia areata. We've come so far, we have a long ways to go, but we're getting there.

And with that, thank you so much for your time. I'll stop sharing my screen and we'll take questions.

LISA ANDERSON, PHD: (46:54)
Thank you, Dr. King. was another great, informative presentation. The first note in the questions is thank you, Dr. King. God bless you for helping us learn and thrive. So I think most of us, everyone on here, it's in agreement that hopefully you can stay a little bit past the top of the hour.

BRETT KING, MD, PHD: (47:10)
For sure, for sure. I'm happy.

LISA ANDERSON, PHD: (47:13)
We have lots of questions. have over 200 people on with us today. So let's get started. This person asks, what's the safety profile of minoxidil?

BRETT KING, MD, PHD: (47:23)
So the safety, it's, know, every one of these questions about safety has to be, right, we kind of have to kind of put guardrails around the answer in the sense that, right, not every medicine is going to be for every person, but minoxidil, oral minoxidil in particular is really quite.

Quite safe. I use it liberally. Probably more than 90 % of my patients are taking it. And somebody who has a considerable cardiovascular or heart history, maybe, well, not maybe, I would, in such a person, I would never say, no, you can't have this. But I would say, I'm gonna call your cardiologist and ask them if this medicine is okay for you.

And by the way, I don't know that I've ever had one of those conversations with a cardiologist and I've had many of them and the cardiologist said, no, no, no, not for this person.

LISA ANDERSON, PHD: (48:20)
Okay, thank you. Here's a person who's writing that their 16 year old has been on, I don't think we need to name the drugs, but one JAK inhibitor for the past two years, limited success, also on two other JAK inhibitors with limited success. Any tips on how to think about our options, giving our lack of success with three different JAK inhibitors?

BRETT KING, MD, PHD: (48:41)
Yeah, yeah, yeah. So it's a great question. now more and more, truly like every month or two, there's another paper being published in the literature saying, if you kind of put them

all together, you would say, well, don't stop. Just if three haven't worked, try four. And because it...

The fourth one will sometimes work. And so I get it, it's discouraging. For sure you want to be in the care of somebody who is not, right, is optimizing the dose of every medicine, right? When somebody says, that medicine didn't work for me. I always wanna know, well, what dose? How long did you take it? If you took it for four months, that's not a trial.

You need to be on a medicine for six or nine months. You need to add oral minoxidil. So there are lots of little nuances, but I would just say as long as all of those nuances are being taken account of, then you reach for the fourth one and you just keep going.

LISA ANDERSON, PHD: (50:00)
Okay, thank you. There are two questions that are similar and they're about changes in someone's alopecia areata. So one person says, what's the right vocabulary to describe someone who has alopecia that appears to be changing spots, then thinning, then regrowth, but patchy and growing spots? And someone else says, is it common for the types of alopecia areata to change?

BRETT KING, MD, PHD: (50:25)
So again, I would encourage all of you to not, nobody has patchy alopecia, you have alopecia areata. If you have spots, you have alopecia areata. If you have diffuse, just diffuse thinning, but no spots. And again, in that case, somebody has done a biopsy to show that you have alopecia areata and not something else like telogen effluvium, or again, to be sure that you have the right diagnosis, it's all alopecia areata. And there's not something, at least there's not something that we're aware of that would make us think differently about the person who used to have spots, now they have no loss, but then they re-grew it spontaneously. Nope, it's all alopecia areata. We think of it the same way.

LISA ANDERSON, PHD: (51:19)
Okay, thank you. Are there plans to create a topical JAK inhibitor?

BRETT KING, MD, PHD: (51:25)
Topical JAK inhibitors have been in clinical trials and they have all failed. So nobody should be buying expensive topical medicines when there is almost no data to support that they grow hair in people with alopecia areata. Certainly not people with moderate. Again, this is a perfect time to use our new vocabulary of mild, moderate and severe, for somebody with 30 % or more scalp hair loss, there's not an ounce of data that they are helpful.

LISA ANDERSON, PHD: (52:01)
Okay, thank you. I've read about a phase two trial that focuses on triggering the T cells that are supposed to normally subdue this overreactive immune reaction as opposed to using immune suppressants. Do you have any thoughts on this therapy? Will it be a future breakthrough in treatment?

BRETT KING, MD, PHD: (52:19)

~ so there's been, there's been a clinical trial, of a medicine that, that sort of has a might, might do this kind of this concept that you're alluding to. it did not work, but again, this is the thing. The immune system is really complicated.

Right, and there are, you know, a million levers, right? It's not like it's one thing. And so the fact that one thing didn't work doesn't mean that we're not, you know, in the future going to have a different way to do this. For instance, right, there are some, if we were to go back to my slide of kind of future or therapies that are in clinical trials, there's recently a clinical trial of a medicine called

Rezpegaldesleukin it's not a JAK inhibitor. It theoretically creates balance in the immune system. There's another clinical trial happening of a medicine called Bempikibart not a JAK inhibitor. Again, another therapy that may in a sense create balance in the immune system as opposed to suppressing engagement of the immune cell and the hair follicle.

There's lots to come.

LISA ANDERSON, PHD: (53:39)
Yeah, hopefully sometime in the future our webinar will be expanded, not just. Great. This question asks, can a spot treated prevent future loss? So if you treat a spot, that prevent future spots from.

BRETT KING, MD, PHD: (53:45)
Yes.

Very good. That is such a cool question. And we don't have an answer. The idea is that if you treat a little bit of alopecia areata, might you prevent a lot of alopecia areata? I don't think that we have any data to say that that's true. so for sure, I would never. You occasionally somebody will come to me with a spot or two and they'll say, but I want, I want a JAK inhibitor because, know, I think that this is bigger than just these two spots. There's, and again, I get the idea. There's truly not an ounce of data to say that that is true.

LISA ANDERSON, PHD: (54:40)
Okay, this is sort of a theme that's running through some of the questions. If you have success on a JAK inhibitor, does that mean you have to continue taking it on an ongoing basis to maintain your growth?

BRETT KING, MD, PHD: (54:54)
The short answer is yes, the vast majority of the time that will be true. However, we have data from the Olumiant clinical trials where they actually tried to answer this question of what happens when people who successfully re-grew come off of medicine and about 10 to 20 % of people kept their hair.

So that's not a hundred percent, right? We would love if the numbers were flipped, right? And it was 80 % kept their hair and 20 % didn't, but 20 % is not zero. And in particular, when you look at what about those 20 % is a little bit different than everybody else, all of them had severe hair loss for a shorter period of time, kind of one to two years.

So it seems as though there's sort of a sweet spot where we might be able to turn things off in at least a minority of people, but maybe if we could get to everybody with one of these medicines in the first two years, maybe 20 % would become 50%. We just don't know yet.

LISA ANDERSON, PHD: (56:08)
Okay, great. More for future. Yes. So we'll know more in the future. Okay. Do you see costs of these meds ever decreasing? Insurance still box at the cost or box of these meds?

BRETT KING, MD, PHD: (56:22)
You know, I'm hopeful that as time goes by that, you know, all of this gets easier. You know, and this is sort of a, you know, this is a meta conversation, honestly, in all of medicine, right? These sorts of medicines that are so kind of sophisticated in their ability to do really interesting things biologically, they often cost a boatload of money.

And we, as a society, as a nation, have to wrestle with how to deal with this. But don't expect necessarily that these medicines are going to get cheaper as there are more of them. And so we can't control that. But you can control who is your senator. And you can control who it is that represents you and insist that they listen on these sorts of issues of affordability of healthcare and medicines.

LISA ANDERSON, PHD: (57:24)
And that's work that NAAF also ~ tries to do through our advocacy work. So we invite you to join us and we'll share information on how to connect with us at the end of the webinar. What about a patient on a JAK who has regrowth but spots that require shots every eight weeks or so that because the shots, the spots keep popping up. that like stay on the same JAK inhibitor, try a different JAK inhibitor?

BRETT KING, MD, PHD: (57:27)
That's right.

~ that is a really, that is a great question. And it's a tricky one to answer. You know, for so again, for, for me, I would always try to optimize quote, medical therapy. So for me, it's like, if you're not, if that the person dealing with this is not on oral minoxidil, I would say, my gosh, for sure. Get on oral minoxidil to see if that adds enough to keep those persistent or those recurring spots from happening. If they continue to happen and it's really annoying, which it often is, a conversation with your dermatologist about switching is not inappropriate.

LISA ANDERSON, PHD: (58:40)
Here's a question. I know you are not a pediatric dermatologist, but I'll ask this question. What would you suggest for a patient under the age of 12 with severe alopecia? My son is 10 and he's in his second ever flare and is currently presenting a severe flare.

BRETT KING, MD, PHD: (58:58)
So I'm not a pediatric dermatologist. I take care of kids. Also, my wife, Britt Craiglow, is a pediatric dermatologist who I think has probably done taking care of more kids with

alopecia areata than anybody on the planet. And so kind of melding my perspective and hers, I mean, absolutely. Like just because these medicines are not approved yet.

under the age of 12, by the way, for alopecia areata. Like, let's be clear, Allumiant outside the US is approved down to age two for eczema, approved down to age two for juvenile arthritis. Rinvoq is approved down to age two for juvenile arthritis. So it's not like there's no data there. It's just that the clinical trials are in progress in those younger kids.

And absolutely these medicines for a 10 year old or an eight year old or a six year old with severe alopecia areata that is affecting them, affecting the family, which it often or usually does for sure. It's the right, the right class of medicines, a struggle to get, maybe a struggle to find somebody who will work that hard to do it, but absolutely appropriate.

LISA ANDERSON, PHD: (1:00:13)
So the age of 12 is not a magic number. It's based on clinical trials and approval of the drugs for other indications.

BRETT KING, MD, PHD: (1:00:24)
Absolutely, Lisa. Just very quickly for everybody. Drugs, when medicines go through clinical trials, the FDA insists first they be tested in people 18 years of age and older. The next group that they permit to be tested or the medicine to be tested in, 12 to 17. After it's been shown to be safe and effective in the 12 to 17 year old age group, then clinical trials happen in 6 to 11 year olds. So again, there's nothing, there's not like a theoretical problem with it. It's just the way medicines are developed.

LISA ANDERSON, PHD: (1:01:03)
I think you used the phrase or you said something about being a second line treatment, maybe with respect to Dupixent. It says, dermatologist, what does second line mean? Our dermatologist is prescribing Dupixent but does not seem to like the Jax. The dermatologist said that Dupixent has a safer side effect profile.

BRETT KING, MD, PHD: (1:01:23)
So the way, and you saw in my treatment algorithm, Dupixent is there. To be clear, the data for Dupixent, it's not nearly as effective as Lifulo Olumiant, Leqselvi.

But for sure, it works for some people. It's just really a relative minority of people. And the reason why dermatologists will sometimes reach for it and maybe not even tell somebody about the JAK and the Bear, but just say, yeah, you should take this medicine called Dupixent is because Dupixent is really, has a very bland side effect profile.

There's just not a whole lot to talk about in terms of warnings or risks or safety. And so that's why a dermatologist will sometimes reach for that first. And again, it's not an unreasonable thing to do, especially in somebody who has eczema and alopecia areata. But again, just to be clear, the weight of evidence for effectiveness is with Litfulo, Olumiant, Leqselvi you know, Renvoq.

LISA ANDERSON, PHD: (1:02:40)

OK. I'm going to ask this question because I want to make sure that this is clear. Is there ever a time when you would use more than one JAK inhibitor at the same time?

BRETT KING, MD, PHD: (1:02:51)
No, never. Absolutely inappropriate. It's just, it's, no, no, not, not, not safe. not ever a reasonable thing to do.

LISA ANDERSON, PHD: (1:03:00)
Okay.

BRETT KING, MD, PHD: (1:03:02)
Just one thing, I just see a question about, you know, my 12 year old, been on Lit Litfulo for four months with no response. Is it worth continuing treatment? Absolutely. And again, that's sort of not necessarily the, you know, we can talk about that sort of in a different setting. but just to be clear, never ever do we stop unless there's a side effect, or think about switching treatment before six months and ideally more like nine months.

LISA ANDERSON, PHD: (1:03:32)
Okay, very good. I was going to ask you that one next time. Where can we find current credible information about the risks of JAKs And someone earlier had asked about the box warning and if you could talk about that a little bit in the context of what the box warning is based on.

BRETT KING, MD, PHD: (1:03:35)
Okay.

So I think Lisa, NAAF has, right, Evan, we addressed this in a NAAF webinar. We do. It might be a nice place to just kind of direct people because it's a big topic. But let me in a minute or two try to answer the question. So all JAK inhibitors have these really ominous warnings, right? called a boxed warning. It includes death, cancer, heart attack, stroke, blood clots. It's really important, really, really important to understand the context of those warnings. Those warnings come from, and I do not say this to be dismissive of risk, never, ever, ever. But those warnings come from clinical trials of people over the age of 50, the average age of the people in the clinical trial I'm referring to is 61, with rheumatoid arthritis. They were all taking, in addition to the JAK inhibitors, Xeljanz, they were taking a medicine called methotrexate, another immune modulating agent. 60 % of them were also taking prednisone, another immune modulating agent.

On average, it was an obese population. Everybody in the clinical trial had to have heart disease. Literally, you had to have heart disease to get into the clinical trial. So older heart disease, a different disease than alopecia areata, obesity, the addition of other medicines, and the risk of a heart attack or a stroke or a cancer was tiny.

tiny. Over five years of observation, the risk was tiny. The risk related to the JAK inhibitor was tiny. And so for me, The vast majority of my patients, and I bet you the vast majority of the people on this call, do not, are not 60, have rheumatoid arthritis, also taking methotrexate, also taking prednisone, and are obese, and have a history of heart attack or stroke or uncontrolled diabetes. And so it's just hard to know. So for me and my patients, the idea is that the risk is tiny.

Even when you have a lot of risk and therefore the risk in most of the people who come to see me who are otherwise healthy and often young is again, it's not, don't ever want to say zero, but it's probably so small that I can't tell you how much risk there is. It's so small.

LISA ANDERSON, PHD: (1:06:38)
Okay, thank you. Just in the chat, we put a link to an older webinar with Dr. Maryanne Sena that focuses on the box warning on JAK inhibitors. And that's another topic that we'll probably address again in the future webinar this year. But thanks for that explanation. There's a couple of questions about how JAK inhibitors work. So this, and I know this is complicated for...just a conversation like this, but for JAK inhibitors, does the mechanism target the underlying autoimmune disorder or do the meds just force hair growth? If that makes sense.

BRETT KING, MD, PHD: (1:07:16)
a great question. So if JAK inhibitors grew hair, I would take one. Because as you can see, I am missing a lot of hair. But they don't. JAK inhibitors don't grow hair. JAK inhibitors address the immune system attacking the hair follicle, which causes the hair follicle to sort of lose the hair or let go of the hair.

And so, so JAK inhibitors and, and, you know, very likely the other medicines that are kind of coming about, you know, are all going to address this sort of, you know, kind of autoimmunity, you know, this, the idea that the immune system is attacking the hair follicle, but none of these medicines, with the exception of oral minoxidil are thought to grow hair.

LISA ANDERSON, PHD: (1:08:09)
Okay. Thank you. This also helped reiterate, which was the treatment which has had clear clinical trial results?

BRETT KING, MD, PHD: (1:08:20)
clear, the Litfulo Olumiant, Leqselvi and again, sort of I think upcoming Rinvoq. These are now kind of three or four medicines for which the data is unambiguous. You have 1200 people in a clinical trial.

~ or clinical trials. Some people get medicine, some people don't for a period of time, everybody eventually gets medicine. And then you see the difference between people who are doing nothing, which is they don't grow hair, and the people who are taking medicine, you know, maybe let's say kind of up to 50 % of people just taking a JAK and everyone will grow their hair. And so those are the medicines, those are the trials for which the data is unambiguous.

LISA ANDERSON, PHD: (1:09:18)

Thank you. Are there any real-world data on how long JAK inhibitors actually stay effective? Everything online only goes up to about four years. Since you're a pioneer in the field, do you have experience with longer?

BRETT KING, MD, PHD: (1:09:33)
Yeah,

yeah, yeah. you know, I now have people who have been taking JAK inhibitors, and by the way, like not hundreds, right? But, you know, 11 and a half years ago, I started a small clinical trial. And in the first six months that I started doing this, you know, I must have started 30, 40, 50, 60 people on Xeljanz back then. And many of those people continue on it to this day.

With, you know, maintenance of success. There are uncommon, it's very rare, but there are uncommon people who do well and then the effect starts to fade. But again, they are 10 % or less of people. Typically, the JAK Inhibitors work and they work and they work and they work. And even in those cases when I've need that they've started to fade the efficacy or the effectiveness has started to fade switching so far so good works

LISA ANDERSON, PHD: (1:10:36)
~ Speaking of Xeljanz this person said, why is Xeljanz not prescribed anymore?

BRETT KING, MD, PHD: (1:10:42)
because we have medicines now that are approved. so, right? So, Xeljanz was born in November, 2012 for the treatment of rheumatoid arthritis. And it was never in a clinical trial for alopecia areata, unless a pharmaceutical company decides to invest 50 or a hundred million dollars to develop a medicine in a disease, it doesn't ever get to a point of possibly being FDA approved. So Zilgians has never been in a, just like I described, a thousand person clinical trial to show that it works. We all know that it works. But again, an insurance company says, show us the data. I know that you, Brett King says, that Xeljanz works, but Xeljanz cost $60,000 a year. And so we insist that you use one of these other expensive medicines for which we can Google and see how well the medicine works.

LISA ANDERSON, PHD: (1:11:53)
Okay, let's just do one or two more and then we'll wrap it up. This person asked, what do you see as the most promising biomarkers on the horizon for personalizing JAK therapy and alopecia areata therapy in general? Are there?

BRETT KING, MD, PHD: (1:12:06)
boy. Are there any? don't think so. No, we're a long ways away from personalized medicine in alopecia areata. We'll get there. But just a quick shout out to participating in clinical trials and in clinical research, right? If you happen to be in the care of a dermatologist who might be doing scalp biopsies and trying to understand what's happening, you know, for those of you who sort of, you know, want to kind of advance knowledge for future generations, you know, participating in a scalp biopsy study or participating in a clinical trial is really useful because I promise you, you know,

That question is a really great question. There's never gonna be an answer until people raise their hand and say, you know, I'm willing to give, you know, a pencil eraser size amount of skin a couple of times to help advance our collective knowledge. But it's hard to do now.

LISA ANDERSON, PHD: (1:13:13)
Okay, thank you. And just to also point out that NAAF maintains a list of active clinical trials on our website. Maybe someone behind the scenes can put that link in the chat as well. And that's a page to keep in mind when you're, you people can help contribute to the science.

BRETT KING, MD, PHD: (1:13:29)
It's so important Lisa. It's both for you, but the idea of staying in for six, nine or nine months or maybe a year, it's again, it's one of the things that I think is so kind of remarkable and so special about the alopecia community is this sense. mean, people will say to me, well, even if it doesn't work for me, I want to advance knowledge so that other people don't have to suffer from this.

It's like, you know, we are all more than just who we are, right? So think about that sometimes.

LISA ANDERSON, PHD: (1:14:06)
Thank you. I'm going to have two more and then we'll stop. Aside from the psychological self-esteem and comfort level, why would a person with universalis for almost 10 years consider the JAK inhibitors? Are there other health benefits, especially since you'd have to stay on the medication permanently to keep the hair?

BRETT KING, MD, PHD: (1:14:24)
I mean, you know, treatment is a deeply personal decision, right? If living with alopecia areata bothers you zero, I can't think of a reason to undertake treatment. For sure, there's not like, and we do not know of any alternative health benefit to...

Taking medicine just to take it. so it just it's right if it's something that you spend a lot of time thinking about you would like to know, does it work for me? If you're somebody with no hair anywhere and you look in the mirror and you say, gosh, wonder, it would be special to have eyebrows. It wouldn't be special to have eyelashes. I would like facial hair. Again, there's no guarantee, right? But it's absolutely the right thing to try. Like for sure, don't let anybody tell you that it's just hair. That's absolutely not true. But it is just hair if it's just hair to you. My point is don't let anybody else tell you it's just hair. If that's how you feel, well, that's cool.

Good for you. But just don't listen to your own voice, listen to your own feelings. It may be that after a decade of hearing doctors be dismissive, you might have a feeling like, well, no, it's not a big deal. If you truly believe it's not a big deal, it's not. If you believe it's a big deal, it's a big deal.

LISA ANDERSON, PHD: (1:16:06)
And just to sort of round that out, the last question I was gonna ask is what's the best way for patients to advocate for themselves in the DERM office? So it kind of already went there,

BRETT KING, MD, PHD: (1:16:17)
It is, I mean, in this and all of healthcare, it's just so critical to go into a visit with as much data as you can possess or learn. You don't want to be combative, but you want to advocate for yourself, right? Because let's face it, in a lot of dermatology visits, somebody's going to walk in the room, look at you, know what the diagnosis is and render a prescription and the whole thing just lasted five minutes and you feel like you've got nothing except for a prescription and you would like to know something about the prescription and you had five other questions. But so I think sort of insisting, mean, honestly insisting and if they don't have time then say, but I have questions and so I would like to know when I can come back and ask these questions. And if you're not the right person and that's okay, right? I don't know all the answers for everybody with every dermatologic condition. I refer people to people who I think are better than me. so, you know, just know as much as you can going into the visit.

And to the extent that you can vet anybody ahead of time, try to since it takes so long to get in to see a dermatologist and probably most doctors. And when you're there, just truly, it's uncomfortable, but you have to insist. I'm here, I came for answers. I know you don't have 30 minutes, but I need to know how you're going to help me answer these questions.

LISA ANDERSON, PHD: (1:17:58)
Excellent advice. I'll share some more NAAF resources in the next slides about to help people find a knowledgeable dermatologist and also some of the other content tools we have for helping with those conversations. I want to say thank you so much for being here and being so generous with your time and expertise. We don't take it for granted that we get to have you on these webinars, but boy, we sure love it when you ~ are here and can have these really frank discussions with the patient community.

BRETT KING, MD, PHD: (1:18:31)
Really my pleasure, Lisa. Thank you so much for having me and thank you to all of you and I wish you the best night.

LISA ANDERSON, PHD: (1:18:37)
Thank you. I'm gonna share my screen again and wrap this up.

Okay, so as I mentioned, I want to just point you to some resources that NAAF has that can help you if you are interested in more information about treatment, working with your healthcare provider. Our new Treatment and Insurance Navigation Toolkit is on our website. It goes in depth on a number of topics, including available treatments, partnering with your healthcare provider.

insurance coverage, patient assistance programs, we welcome you to check that out. Get in touch with us if you have any questions that we might be able to help you with. And then keep in mind that if you're looking for a knowledgeable dermatologist, please check out the Dr. Finder on the NAAF website. This is something that frequently comes up on these webinars, how to find the right dermatologist or advanced practice provider for you. You can use this QR code to get to the Dr. Finder.

And the Dr. Finder lists board certified dermatologists in the U.S. with experience in treating alopecia areata. Our listing also includes ~ dermatology nurse practitioners and physician assistants. You can search the list by state to try to find somebody close to you who can support you. I also want to remind you that NAAF's 41st annual conference is coming. It's not too early to register. This is an opportunity to hear Dr. King speak in person at the conference as well as other leaders in Alopecia areata. The conference will take place in Orlando, Florida from June 25th to June 28th. The conference is the largest gathering of the Alopecia areata community in the world and you are invited. It's a unique opportunity to hear from experts, connect with community leaders in Alopecia areata and meet others who share similar experiences. We're currently offering an early bird registration discount that will save you $100 on the registration fee.

So please register today. We'd love to see you in Orlando.

I want to thank Dr. King again for being on our webinar. I also want to thank you, our audience, for being with us today. Please share your feedback on today's webinar and help us plan for future presentations. A link to a short survey will pop up in the browser window at the end of the webinar. We always appreciate your feedback.

Please join us for our next webinar, Parenting a Child with Alopecia, Supporting Your Child Without Transferring the Weight. Parenting a child with alopecia areata can bring up complex emotions, grief, guilt, fear, and a deep desire to protect. While these feelings are natural, they can unintentionally add emotional weight to a child who is already navigating their own experience. This webinar will explore how parents can acknowledge and process their own emotions without transferring that burden to their child. Our speaker will be Janelle Massey, licensed mental health therapist and an alopecia areata parent. Please join us for this informative presentation and Q &A session. This webinar will take place on Tuesday, March 10th at 7 p.m. Eastern, 4 p.m. Pacific. And registration for this webinar is now open. You can scan this QR code to register. We encourage you to stay in regular touch with NAAF. Subscribe to our email list for regular updates on alopecia areata news and research, the monthly NAAF electronic newsletter, and notices about upcoming webinars and other programs like our advocacy program that we talked about a little bit with Dr. King. To learn more about NAAF and the resources we offer, please visit naaf.org or email us at support at naaf.org. This concludes today's webinar program. Thank you so much for joining us. We look forward to seeing you on the next webinar.