



LETTER TO THE EDITOR

A rare type of trichotillomania: rhinotillexomania

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Dear Editor,

Trichotillomania (or hair-pulling disorder) is a psychiatric disorder characterized by repetitive chronic hair pulling that can result in serious hair loss. While having been familiar for many years, little is known about its epidemiology, etiology, and subtypes. In the DSM-IV-TR, trichotillomania was classified as an impulse-control disorder (1), whereas in the DSM-5, it falls under the new category of Obsessive-Compulsive and Related Disorders (2). Epidemiological studies of trichotillomania are limited, but current prevalence studies suggest that it is a common disorder (3). Trichotillomania can cause significant distress/impairment in all areas of life. The course of trichotillomania may vary from individual to individual. It is most often considered to be a chronic disorder that tends to fluctuate over time. In trichotillomania, pulling can start in any piliferous region of the body, spreading to other areas over time. The scalp is the most common site for pulling hair. Pulling typically begins on the scalp, eyebrows, and eyelashes, but sometimes in other areas, too, and sites may vary over time. 'Rhinotillexomania' is a behavior rarely seen in patients diagnosed with trichotillomania, and it is usually not recorded unless the patient is questioned. It can be described as nose hair pulling, and it may cause severe health problems. It has been proposed that rhinotillexomania, treated only in a limited number of studies and only at the level of case presentations, may be placed among the obsessive compulsive disorders. It presents with body-focused repetitive behaviors and deliberate self-harming behavior, and it is a subtype of

trichotillomania. A serious problem only occurs if rhinotillexomania causes severe impairment of daily life or medical problems (like epistaxis). Information about the treatment of rhinotillexomania is quite limited and there is no agreement about best practice (4-8).

In this report, we present a 30-year-old male, single, unemployed university graduate admitted to our psychiatry outpatient department accompanied by his mother with the complaint of anhedonia, feeling unhappy, excessive attention to detail, pulling hair from the scalp, eyelashes, eyebrows, and moustache in stressful situations, starting around age 12-13 years. In the psychiatric interview, it was learned that especially in the last months, after tearing at his moustache, the patient also pulled his nose hair, using tweezers and a nail clipper for the parts that he could not reach with his fingers. It was also found that the patient, especially when feeling more stressed and being alone, would tear out hairs from his moustache and beard by deflecting them into his mouth while watching TV or reading, without feeling any pain in the process. In the physical examination, severe losses in the patient's eyebrows, eyelashes, and moustache were observed. He cut his beard and moustache short and was wearing thick rimmed glasses when going out. It was also reported that his sister was diagnosed with onychophagy (or chronic habitual nail-biting) and his mother with obsessive-compulsive disorder.

After psychiatric evaluation, 50 mg/day sertraline was suggested with the diagnosis of major depressive disorder, trichotillomania according to DSM-5, and rhinotillexomania (not yet included in the diagnostic classifications). The dose was gradually increased to

How to cite this article: Sonmez D, Hocaoglu C. A rare type of trichotillomania: rhinotillexomania. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences* 2019;32:279-280.

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Received: April 06, 2018; **Revised:** May 14, 2018; **Accepted:** June 14, 2019

mg/day. However, no clinical change was observed in the complaints of the patient who was simultaneously treated with habit reversal therapy, mindfulness training, stimulation control, relaxation, and response inhibition techniques for trichotillomania and rhinotillexomania. Aripiprazol 2.5 mg/day was added to the treatment of the patient whose depressive complaints decreased in the 8th week. The patient is still in treatment, and the habit of pulling hair, eyebrows, eyelashes and nose hairs has significantly decreased.

If left untreated, trichotillomania is a chronic psychiatric disorder that often results in serious psychosocial dysfunction and can in rare cases lead to life-threatening medical problems. Most trichotillomania patients may hide their symptoms and be unwilling to be treated. As a result, diagnosis and treatment may be late. In addition, sometimes clinicians may fail to notice conditions such as rhinotillexomania, which is rarely seen because physicians may take trichotillomania into consideration only in the hairy parts of the body such as the scalp, eyelashes, and eyebrows. Cases of rhinotillexomania can present with a variety of symptoms, including recurrent epistaxis, upper respiratory infections, and abnormalities in the nasal cartilage tissue (9). Thus, clinicians being attentive

towards rhinotillexomania, which has been reported to cause fatalities, can save lives.

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