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Original Article

Korean Consensus Criteria for the Severity Classification of Alopecia Areata

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ABSTRACT

Background: A set of criteria for severity classification is essential in alopecia areata (AA). Currently, no guidelines are universally accepted for defining AA severity.
Objective: This study aimed to establish a set of consensus criteria for classifying the severity of and identifying treatment refractoriness in AA.
Methods: A preliminary draft of the definition for moderate-to-severe AA was crafted based on available evidence, and members of the Korean Hair Research Society (KHRS) subsequently endorsed the recommendation through an online survey.
Results: In the first Delphi round, consensus was attained on 15 questions. After refining certain items in the second round, consensus was achieved on 23 out of 26 questions. The KHRS first defined AA severity using the severity of alopecia tool (SALT). SALT ≥50 was defined as severe, 20≤ SALT <50 as moderate, and SALT <20 as mild. Moderate AA was considered severe if it meets one or more of the following criteria: dermatology life quality index >10, presence of

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accompanying eyebrow or eyelash loss, positive hair loss activity, or treatment-refractory AA.
Conclusion: These consensus criteria can help clinicians accurately diagnose AA, provide appropriate treatment, and monitor its progression.

Keywords: Alopecia areata; Consensus; Criteria; Severity

INTRODUCTION

The severity of alopecia areata (AA) can vary greatly among individuals, with some people experiencing only a few small patches of hair loss, whereas others may lose all of their hair[1].

A set of criteria for grading AA severity serves multiple purposes, from informing treatment decisions to supporting research and improving the overall care of the affected individuals[2]. Standardized guidelines help dermatologists in assessing the extent and severity of AA. This information is crucial for making treatment decisions[2,3]. The severity of AA can significantly affect the choice of treatment. Mild cases might respond well to topical treatments or lesional injections, whereas severe cases may require systemic medications[2]. These guidelines also allow for consistent classification of severity in clinical trials and research[4]. In some cases, the insurance coverage for the treatment of AA may depend on its severity. Clear classification guidelines help in the reimbursement process.

However, no standard has been globally accepted for defining severe AA[5-7]. Severe AA is often defined by the extent of scalp hair loss; however, even the criteria for this extent vary worldwide, and the methods for measuring the area also differ in various situations[6,8-11]. The criteria for severity have mostly been arbitrarily established rather than based on expert consensus[4]. Furthermore, considerable uncertainty remains regarding diagnostic criteria for moderate AA.

Thus, this study aimed to construct, using the Delphi methodology, a framework for assessing AA severity to assist all dermatologists in treating AA.

MATERIALS AND METHODS

Study design

In this study, a modified Delphi method was utilized, which comprised two rounds to formulate a definition for moderate-to-severe AA[12,13]. The rounds were sequentially conducted from February 2023 to August 2023. The eDelphi format facilitated the electronic distribution of questionnaires for both rounds using Google Forms (http://forms.google.com).

The responses to the individual questionnaires were handled confidentially, and ethical standards were observed.

Expert panel selection

In January 2023, the Korean Hair Research Society established a task force with a core team, which consisted of nine members. Then, core team invited 56 dermatologists who specialized in hair loss disease and were considered as having sufficient experience in AA as expert panel. Among the 56 expert panel members, 42 participated and completed both rounds of the questionnaire survey. Consent to participate was considered implicit through self-registration and completion of the surveys.

Delphi survey

The study core team crafted online surveys to define the severity criteria and to evaluate responses. A systematic literature search was conducted to formulate questions to define the severity of AA. These questions were formulated to seek the clinical experiences and opinions of experts of AA in Korea on clinically significant topics. The core team provided references, reference summaries, and level of evidence for each question.

Delphi process

The Delphi process was selected as the methodology to establish consensus among experts regarding the definition of moderate-to-severe AA. Accordingly, a two-round questionnaire survey was employed. **Fig. 1** shows the Delphi rounds.

1) Round 1

All experts were emailed with a questionnaire comprising 8 topics and 25 questions. For each statement, panel members indicated their response as either "yes," "neutral," or "no." In some questions, participants were asked to choose the most appropriate item that reflects the degree of severity from a list of multiple choices. Panel members were permitted to provide additional comments and feedback in free-text format.

2) Round 2

The round 2 survey questionnaire was crafted based on the results of round 1 and the insights of the experts. This survey consisted of 8 topics and 26 questions. In round 2, participants selected one of the following answers for each statement: "strongly agree," "agree," "neutral," "disagree," "very disagree," and "other (withhold judgment, etc.)."

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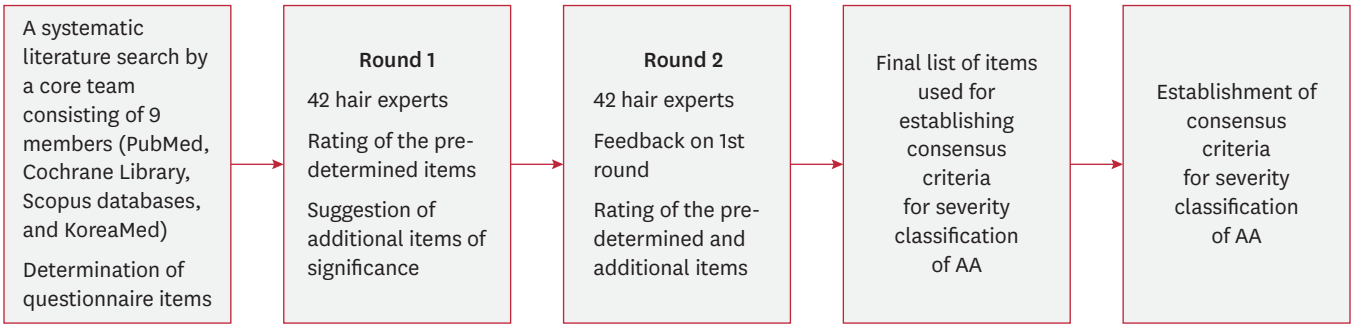

Fig. 1. Flowchart of the Delphi study building toward reporting the AA severity criteria.
AA: alopecia areata.

Consensus threshold

Consensus regarding the aspects to be incorporated in the reporting guidelines was determined as an agreement of at least 70%[14], with the disagreement rate of <20%[15], as predefined before the study started. By applying the above criteria, consensus was reached if >70% of all participants responded "yes" in the first round. For the second round, the consensus threshold was set at >70% agreement, taking into consideration responses of "strongly agree" and "agree."

RESULTS

Among 56 experts, 42 (75.0%) completed rounds 1 and 2. Of the 42 experts, 35 (83.3%) and 7 (16.7%) work in public hospitals and exclusively in private practice, respectively. **Table 1** presents an overview of the demographic characteristics of the 42 experts.

Summary of consensus outcomes

1) Round 1

Agreement ratings

Out of the 25 questions, consensus was reached on 15 questions (**Table 2**).

2) Round 2

Integration of comments from round 1. In round 2, some items in the first round were rephrased, and new questions have been added based on the comments from the experts.

Table 1. Characteristics of survey responders

Characteristics	Total (n=42)
Age (yr)	51.1±8.0
Sex	
Male	35 (83.3)
Female	7 (16.7)
Academic degree/position	
MD	42 (100)
PhD	41 (97.6)
Professor	35 (83.3)
Dermatologist experience (yr)	20.0±8.1
Research work experience (yr)	20.9±8.2

Values are presented as mean±standard deviation or number (%).

Agreement ratings

Consensus was achieved in 23 of 26 questions (**Table 2**). The final list of items used for establishing consensus criteria for the classification of AA severity is as follows:

1) A measurement tool that can define the extent of hair loss
- Would it be appropriate to use the severity of alopecia tool (SALT) in evaluating the extent of hair loss when defining severe AA?

2) Range of moderate and severe AA defined by the extent of hair loss
- Would it be appropriate to define severe AA as the extent of hair loss of ≥50%?
- Would it be necessary to establish criteria for moderate AA?
- Would it be appropriate to define moderate AA as the extent of hair loss of 20%–49%?
- Would it be plausible that factors other than the extent of hair loss affect the definition of severe AA?
- Would it be appropriate/acceptable if moderate AA based on the extent of hair can be categorized as severe AA when clinical variables suggesting a more severe condition, as in AA scale, are accompanied[9]?

3) Inclusion of a quality of life (QoL) measurement tool in the severity assessment
- Would AA affect patients' QoL?
- Would it be appropriate to include QoL measurement in AA severity assessment?
- Would it be appropriate to use the dermatology life quality index (DLQI) to evaluate the QoL of patients with AA?
- Would it be appropriate to define severe QoL deterioration in AA as exceeding a DLQI score of 10?
- Would AA in children affect patients' QoL?

Table 2. Items for the consensus criteria of AA severity and their agreement ratings in rounds 1 and 2

Item No.	Round 1				Round 2						
	Items	Rating (yes/neutral/no)	Agreement (% of yes)	Disagreement (% of no)	Items	Rating (strongly agree/agree/neutral/disagree/very disagree)	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Very disagree (%)
	A measurement tool that can define the extent of hair loss										
1	Which of the following assessments do you think is the most appropriate for the diagnosis of severe AA?	SALT (20/42, 47.6%) AA scale (12/42, 28.6%) Evaluate the area of the hair loss (6/42, 14.3%) AA-IGA (4/42, 9.5%)			Would it be appropriate to use the SALT in evaluating the extent of hair loss when defining severe AA?	21/20/0/0/1	50.0	47.6	0	0	2.4
	Range of moderate and severe AA defined by the extent of hair loss										
2	Would it be appropriate to define severe AA as the extent of hair loss of ≥50%	28/0/14	66.7	33.3	Would it be appropriate to define severe AA as the extent of hair loss of ≥50%?	18/19/2/3/0	42.9	45.2	4.8	7.1	0
3	Would it be appropriate to define severe AA as the extent of hair loss of ≥25%?	15/0/27	35.7	64.3	Would it be appropriate to define severe AA as the extent of hair loss of ≥25%?	2/17/8/14/1	4.8	40.5	19.0	33.3	2.4
4	Would it be necessary to establish criteria for moderate AA?	32/0/10	76.2	23.8	Would it be necessary to establish criteria for moderate AA?	17/21/3/0/1	40.5	50.0	7.1	0	2.4
5	Would it be appropriate to define moderate AA as the extent of hair loss of 20%–49%?	26/0/6	81.3	18.7	Would it be appropriate to define moderate AA as the extent of hair loss of 20%–49%?	11/27/2/2/0	26.2	64.3	4.8	4.8	0
6	Would it be possible that factors other than the extent of hair loss affect the definition of severe AA?	39/0/3	92.9	7.1	Would it be plausible that factors other than the extent of hair loss affect the definition of severe AA?	15/21/5/0/0/1*	35.7	50.0	11.9	0	0
7					Would it be appropriate/acceptable if moderate AA based on the extent of hair can be categorized as severe AA when clinical variables suggesting a more severe condition, as in alopecia areata scale, are accompanied[9]?	15/24/3/0/0	35.7	57.1	7.1	0	0
	Inclusion of a QoL measurement tool										
8	Would AA affect patients' QoL?	41/0/1	97.6	2.4	Would AA affect patients' QoL?	39/3/0/0/0	92.9	7.1	0	0	0
9	Would it be appropriate to include QoL measurement in AA severity assessment?	31/0/11	73.8	26.2	Would it be appropriate to include QoL measurement in AA severity assessment?	14/16/10/2/0	33.3	38.1	23.8	4.8	0
10	Would it be appropriate to use the DLQI to evaluate QoL in patients with AA?	39/0/3	92.9	7.1	Would it be appropriate to use the DLQI to evaluate QoL of patients with AA?	11/25/6/0/0	26.2	59.5	14.3	0	0
11	Would it be appropriate to define severe QoL deterioration in AA as exceeding a DLQI score of 10?	40/0/2	95.2	4.8	Would it be appropriate to define severe QoL deterioration in AA as exceeding a DLQI score of 10?	13/25/4/0/0	31.0	59.5	9.5	0	0

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Table 2. (Continued) Items for the consensus criteria of AA severity and their agreement ratings in rounds 1 and 2

Item No.	Round 1				Round 2						
	Items	Rating (yes/ neutral/ no)	Agreement (% of yes)	Disagreement (% of no)	Items	Rating (strongly agree/agree/ neutral/disagree/ very disagree)	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Very disagree (%)
12	Would AA in children affect patients' QoL?	42/0/0	100.0	0.0	Would AA in children affect patients' QoL?	38/4/0/0/0	90.5	9.5	0	0	0
13	Would it be appropriate to use CDLQI for QoL evaluation in pediatric patients with AA?	39/0/3	92.9	7.1	Would it be appropriate to use CDLQI for QoL evaluation in pediatric patients with AA?	12/23/6/1/0	28.6	54.8	14.3	2.4	0
	Evaluation of eyebrow and eyelash loss										
14	Would it be appropriate to consider eyebrow or eyelash loss in AA severity assessment?	39/0/3	92.9	7.1	Would it be appropriate to consider eyebrow or eyelash loss in AA severity assessment?	16/25/1/0/0	38.1	59.5	2.4	0	0
15	If considering eyebrow or eyelash loss in AA severity assessment, which area should be included?	Eyebrow and eyelash (36/39, 92.3%) Eyebrow only (3/39, 7.7%)			Would it be appropriate to include both eyebrow and eyelash when assessing hair loss in the eyebrow or eyelash?	14/26/2/0/0	33.3	61.9	4.8	0	0
16	What method do you think is appropriate for evaluating eyebrow loss?	Existence of hair loss (16/39, 41.0%) Scoring degree of gap (15/39, 38.5%) Categorizing (0–3) the amount of eyebrows (8/39, 20.5%)			Would it be appropriate to use an evaluation tool that checks the presence or absence of noticeable hair loss to reflect eyebrow/eyelash loss in AA severity?	6/29/6/1/0	14.3	69.0	14.3	2.4	0
17	What method do you think is appropriate for evaluating eyelash loss?	Existence of hair loss (16/36, 44.4%) Scoring degree of gap (15/36, 41.7%) Categorizing (0–3) the amount of eyelashes (5/36, 13.9%)			Would it be appropriate to use an evaluation that scores according to the degree of gap caused by hair loss to reflect eyebrow/eyelash loss in AA severity?	1/20/17/3/1	2.4	47.6	40.5	7.1	2.4
	Inclusion of hair loss activity										
18	Would it be appropriate to include hair loss activity in addition to hair loss extent in AA severity assessment?	29/0/13	69.0	31.0	Would it be appropriate to include hair loss activity in AA severity assessment?	13/20/5/3/1	31.0	47.6	11.9	7.1	2.4
19	What method do you think is appropriate for objective evaluation of hair loss activity in AA?	Dermoscopic findings and hair pull test (20/29, 69.0%) Hair pull test only (6/29, 20.7%) Dermoscopic findings only (3/29, 10.3%)			Would it be appropriate to include a hair pull test as an objective evaluation method for hair loss activity in AA?	16/24/2/0/0	38.1	57.1	4.8	0	0
20					Would it be appropriate to include dermoscopic findings (positive if exclamation mark hair, broken hair, or black dots) as an objective evaluation method for hair loss activity in AA?	10/21/11/0/0	23.8	50.0	26.2	0	0
	Definition of treatment-refractory AA (nonresponder)										
21	Would it be appropriate to include inadequate/ insufficient response to treatment in the evaluation of AA severity?	36/0/6	85.7	14.3	Would it be appropriate to include inadequate/ insufficient response to treatment in the evaluation of AA severity?	17/23/1/1/0	40.5	54.8	2.4	2.4	0

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Table 2. (Continued) Items for the consensus criteria of AA severity and their agreement ratings in rounds 1 and 2

Item No.	Round 1				Round 2						
	Items	Rating (yes/ neutral/ no)	Agreement (% of yes)	Disagreement (% of no)	Items	Rating (strongly agree/agree/ neutral/disagree/ very disagree)	Strongly agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Very disagree (%)
22	Would it be appropriate to define treatment-refractory AA as an AA that failed to reach $SALT_{30}$ after 24 weeks of appropriate treatment?	33/0/9	78.6	21.4	Would it be appropriate to define treatment-refractory AA when a patient fails to achieve $SALT_{30}$ or still has >20% scalp hair loss despite 24 weeks of appropriate treatment?	10/28/3/1/0	23.8	66.7	7.1	2.4	0
23	Would it be appropriate to define treatment-refractory AA as AA with≥ 20% hair loss after appropriate treatment?	29/0/13	69.0	31.0							
24	Would vellus hair regrowth be considered an appropriate response to treatment?	27/0/15	64.3	35.7	Would regrowth of vivid vellus hair (thin hair with straight-up position and tapered distal endings) be considered an appropriate response to treatment?	7/32/3/0/0	16.7	76.2	7.1	0	0
	Definition of recurrent AA										
25	Would it be appropriate to include recurrence in the evaluation of AA?	27/0/15	64.3	35.7	Would it be appropriate to include “recurrence” in the evaluation of AA?	10/18/12/2/0	23.8	42.9	28.6	4.8	0
26	Would it be appropriate to define recurrent AA when experiencing two or more new alopecic patches within 1 year after a complete cure of AA?	34/0/8	81.0	19.0	Would it be appropriate to define recurrent AA when experiencing two or more new alopecic patches within 1 year after a complete cure of AA?	7/32/2/1/0	16.7	76.2	4.8	2.4	0
	Need for separate pediatric criteria different from adults										
27	Would it be appropriate to use the same severity measurement tools for children as those for adults?	37/0/5	88.1	11.9	Would it be appropriate to use the SALT for adults in children?	7/26/7/2/0	16.7	61.9	16.7	4.8	0

AA: alopecia areata, SALT: severity of alopecia tool, IGA: investigator global assessment, QoL: quality of life, CDLQI: children’s dermatology life quality index, DLQI: dermatology life quality index, $SALT_{30}$: SALT score improvement of ≥30%.
*Pending judgment.

- Would it be appropriate to use children’s DLQI for QoL evaluation in pediatric patients with AA?

4) Evaluation of eyebrow and eyelash loss in the severity assessment

- Would it be appropriate to consider eyebrow or eyelash loss in AA severity assessment?
- Would it be appropriate to include both eyebrow and eyelash when assessing hair loss in the eyebrow or eyelash?
- Would it be appropriate to use an evaluation tool that checks the presence or absence of noticeable hair loss to reflect eyebrow/eyelash loss in AA severity?

5) Inclusion of hair loss activity in the severity assessment

- Would it be appropriate to include hair loss activity in AA severity assessment?
- Would it be appropriate to include a hair pull test as an objective evaluation method for hair loss activity in AA?
- Would it be appropriate to include dermoscopic findings (positive if exclamation mark hair, broken hair, or black dots) as an objective evaluation method for hair loss activity in AA?

6) Definition of treatment-refractory AA (nonresponder)

- Would it be appropriate to include inadequate/insufficient response to treatment in the evaluation of AA severity?

- Would it be appropriate to define treatment-refractory AA when a patient fails to achieve SALT score improvement of ≥30% ($SALT_{30}$) or still has >20% scalp hair loss despite 24 weeks of appropriate treatment?
- Would regrowth of vivid vellus hair (thin hair with straight-up position and tapered distal endings) be considered an appropriate response to treatment?

7) Definition of recurrent AA

- Would it be appropriate to define recurrent AA when experiencing two or more new alopecic patches within 1 year after a complete cure of AA?

8) Need for separate pediatric criteria different from adults

- Would it be appropriate to use the same severity measurement tool (SALT) for children as those for adults?

Establishment of consensus criteria for the severity classification of AA

The consensus criteria for the classification of AA severity were made based on the agreement (**Fig. 2**). In addition, Korean AA experts have reached a consensus on the definition of recurrent AA and appropriate treatment response.

- Recurrent AA is defined as "experiencing two or more new alopecic patches within 1 year after a complete cure of AA."
- Appropriate treatment response is assessed by "regrowth of vivid vellus hair (thin hair with straight-up position and tapered distal endings)."

DISCUSSION

AA shows very diverse clinical pictures for each patient. Therefore, an appropriate scaling system to determine severe AA is necessary to decide the patient's prognosis and treatment response, as treatment differs according to the severity[3].

In this study, the experts agreed to use SALT as a measurement tool that can define the extent of hair loss in both adult and pediatric patients. Apart from adult patients, the use of the scoring system in adults in pediatric patients requires careful consideration, and the application of SALT in pediatric patients may have certain limitations. A previous study showed that children aged <12 have a percentage difference in the hair-bearing scalp from adults and concluded that children aged 2–11 years need a pediatric SALT scoring system. However, in the current manual SALT scoring method, a change of 2% might not affect the overall SALT score[16].

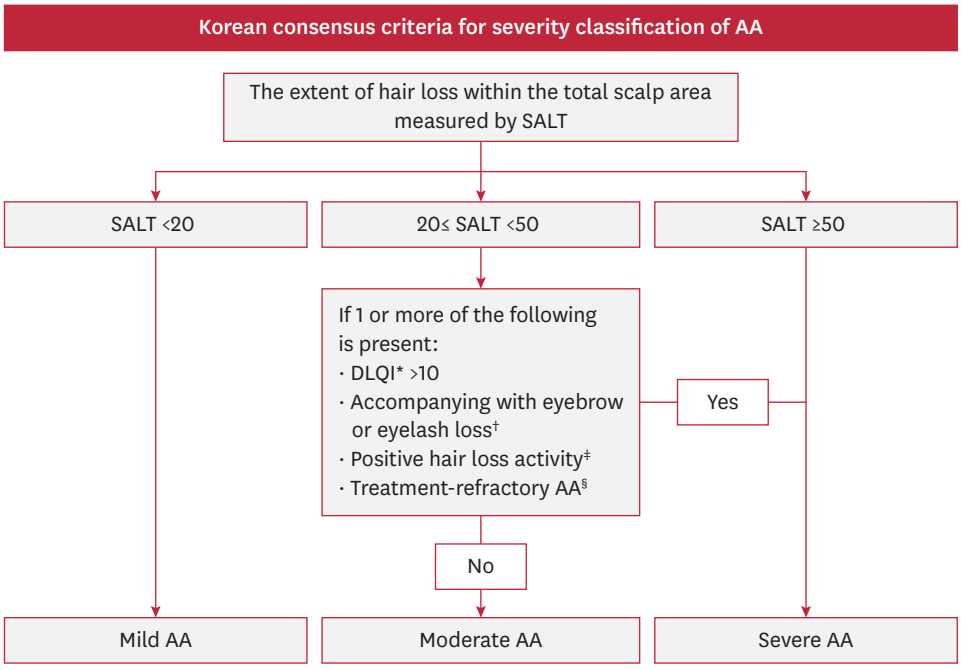

Fig. 2. Korean consensus criteria for the severity classification of AA.
AA: alopecia areata, SALT: severity of alopecia tool, DLQI: dermatology life quality index.
*In pediatric patients, the children's dermatology life quality index is used.
†Investigate "whether there is distinct eyebrow or eyelash loss" when assessing AA severity.
‡Investigated by "positive hair pull test or dermoscopic findings (black dots, tapering hair, and broken hairs)."
§Treatment-refractory AA: failure to reach SALT score improvement of ≥30% or still has >20% scalp hair loss despite 24 weeks of appropriate treatment?

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In this survey, 88.1% of the respondents agree to define severe AA as the extent of hair loss of ≥50%. When hair loss of 25% was proposed as a criterion for severe AA, agreement dropped to 45.2%, suggesting that a threshold of hair loss of 50% is more widely accepted for defining severe AA. Several studies based on expert consensus have similarly defined severe AA as cases involving hair loss of 50%. For example, King et al.[9] defined severe hair loss as ≥50% based on a survey of 22 clinical experts, and Wyrwich et al.[10] categorized 50%–94% of hair loss as severe and 95%–100% as very severe in the AA investigator global assessment scale. In addition, Meah et al.[17] divided the clinical severity of AA into three grades, defining the highest severity as a SALT score >50, although they did not explicitly label this as "severe." Consistent with these findings, national guidelines in Australia[5] and Brazil[18] also define severe AA based on hair loss of 50% or SALT 50. However, the Japanese guideline[19] proposed severe AA with an alopecic extent of ≥25%, which is equivalent to S2 severity based on the classification proposed by the National AA Foundation in 1999[20].

Respondents demonstrated agreement (92.9%) that other clinical variables should be incorporated into the evaluation of AA severity, in addition to the extent of hair loss. Thus, even if the extent of scalp hair loss corresponds to moderate AA, it should be classified as severe if it is accompanied by clinical variables indicating a more serious condition. These findings underscore the need for a clear definition of not only severe but also moderate AA. However, the classification for "moderate" is not clearly delineated in existing literature. Previous suggestions based on expert consensus have defined moderate AA as cases presenting 21%–49%[9,10] or 31%–50%[17] of hair loss. Notably, the proposed criteria, which defined moderate AA as cases presenting 20%–49% of hair loss, received substantial agreement (90.5%) among respondents.

The chronic, relapsing, and unpredictable nature of AA, as well as its effects on appearance, can significantly influence patients' QoL. Recent systematic reviews consistently have demonstrated that individuals with AA often experience emotional and psychological distress, resulting in impaired QoL[21,22]. Furthermore, the effect of AA on QoL, as measured by scales such as DLQI, is comparable to that of other chronic skin conditions such as psoriasis and atopic dermatitis (5.3–13.54 vs. 5.83–13.4 and 7.31–10.63)[23]. A recent study emphasized the importance of including QoL as a key outcome measure in future studies, and experts agree that depression, anxiety, and psychosocial effects related to AA are significant factors in determining AA severity, in addition to the degree of scalp hair loss[9]. Similarly, in the present study, expert consensus was achieved for the inclusion of QoL measurement in AA severity assessment.

Various tools, such as Skindex and the Short-Form Health Survey-36, can be used to assess QoL. However, the DLQI, a validated instrument widely used to assess QoL in patients with various skin conditions, is recommended. This recommendation is supported by recent systematic reviews, which revealed that the majority of previous studies (15 out of 34) used the DLQI to measure QoL in adult patients with AA[22]. A previous study interpreted DLQI total scores as follows: 0–1, no effect on the patient's life; 2–5, small effect; 6–10, moderate effect; 11–20, very large effect; and 21–30, extremely large effect[24]. The majority of experts in this study agreed with this interpretation.

The eyebrow and eyelash loss are very bothersome to patients with AA both physically and psychologically[25,26]. In several clinical trials of AA treatments, improvements in eyebrow and eyelash loss have been used as criteria for assessing treatment effectiveness[27,28]. Although several methods have been proposed to assess the severity of AA of the eyelashes and eyebrows, a consensus has not yet been reached[9,11,29,30]. To reflect on the condition of the eyebrows and eyelashes when assessing AA severity, a survey questionnaire was developed based on a literature review, an expert survey was conducted, and consensus was made as "whether or not distinct eyebrow or eyelash loss."

Hair loss activity reflects impending hair loss area in AA. The rapid progression has been regarded as an important factor for assessing AA severity[9,31]. A positive hair pull test reflects impending hair loss and is an objective marker of the progression of hair loss[32]. Thus, in the AA scale, a diffuse positive hair pull test was included as a secondary criterion for increasing AA severity rating[9]. Dermoscopic findings such as black dots, tapering hair, and broken hairs are also indicators of hair loss activity in AA[33]. Therefore, in the questionnaire survey, these two well-known simple clinical evaluation methods for hair loss activity in AA were included: hair pull test and dermoscopic findings.

Some patients with AA are not categorized into severe AA according to the extent of hair loss; however, they are refractory to treatment. The panel agreed to include treatment refractoriness in AA severity assessment. Previous studies have set different treatment durations of 6–12 months before a patient was considered to have had an insufficient response[34-37]: 24 weeks was chosen as the most comprehensive timeframe for understanding treatment response. The definition of inadequate response to treatment varied from none to some levels of hair regrowth by studies. Many recent clinical trials have adapted achieving $SALT_{30}$ as treatment response and failure to reach $SALT_{30}$ as the absence of response[34,35]. Achieving a SALT score of ≤20 was also reported as a clinically meaningful treatment outcome for patients with a baseline SALT score of ≥50[10,27]. The expert panel agreed to define treatment-refractory AA as failure to reach $SALT_{30}$ or hair loss of ≥20% of the total scalp despite 24 weeks of treatment.

We also tried to develop a definition of recurrent AA by reviewing literature with information about recurrence rate or time to recurrence, which is related to major treatment modalities[38-43].

Table 3. Clinical studies providing information on recurrence in AA recurrence

Treatment modalities	Study type	Recurrence rate	Time to recurrence
JAK inhibitor[33]	Systematic review	54% of 5 RCT and 9 non-RCT	After dose reduction or discontinuation of JAK inhibitor
Cyclosporine[34,35]	Systematic review: cyclosporine with/without steroid	47% of 213 AA and 127 AU/AT patients[34] 55% (6%–96%) in cyclosporine monotherapy vs. 28% (6%–72%) in steroid combination therapy[35]	6.75 mo (range 2–36 mo)[34] N/A
Methotrexate[36]	Systematic review and meta-analysis: methotrexate with/without steroid	47%	After dose reduction or discontinuation of methotrexate or steroid
Corticosteroid[37]	Retrospective observational study treated with intravenous methylprednisolone	7 out of 10 patients (13 AA and 5 AU/AT children) with hair growth of more than 75%	8 mo (median)
DPCP[38]	Retrospective observational study	44% of 50 patients	20 mo (5–54 mo)

AA: alopecia areata, JAK: Janus kinase, RCT: randomized clinical trials, AU: alopecia universalis, AT: alopecia totalis, N/A: not available, DPCP: diphenylcyclopropenone.

Although the disease severity of the participants, treated drugs, and regimen were heterogeneous between studies, recurrence was observed in 44%–70% of patients with AA within 6–12 months after treatment cessation or dose reduction of these drugs (**Table 3**)[38-43]. Based on the time to relapse and a major factor of recurrence from previous studies, recurrent AA was defined as "experiencing two or more new alopecic patches within 1 year after a complete cure of AA." Korean hair experts thought that classifying all recurrent AA cases into the severe category is inappropriate. Nevertheless, the unmet need for special consideration in these patients has led to the development of new definition of recurrent AA, and a consensus was achieved.

This study defined severity guidelines for AA through a consensus among Korean hair experts. While guidelines from other countries[5,6,18,19] typically focused on suggesting treatment methods based on the extent of hair loss, the location and number of alopecic patches, this criterion integrated various factors such as QoL, involvement of eyebrow or eyelash, hair loss activity, and treatment responsiveness. King et al.[9] also suggested severity criteria for AA composed of the extent of hair loss and subjective evaluation of clinical features. However, through two consecutive Delphi rounds, we refined the severity classification criteria for AA, offering more detailed value.

This study presents up-to-date, evidence-based criteria for classifying AA severity. They are the result of expert consensus adding diversity to previous guidelines. These consensus criteria can help clinicians accurately diagnose AA, provide appropriate treatment, and monitor its progression.

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CONFLICTS OF INTEREST

The authors have nothing to disclose.

DATA SHARING STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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