Understanding *Hair Loss*

How hair loss can appear in men and women - and how regenerative care compares with hair transplantation.

IMPORTANT CONTEXT Hair loss has many causes, and the correct diagnosis determines the treatment. Regenerative procedures do not work for every condition, cannot revive follicles that are no longer viable, and should not delay evaluation of sudden, painful, patchy, or scarring hair loss.

HAIR LOSS IS NOT ONE CONDITION

Genetics, hormones, illness, childbirth, rapid weight change, medications, nutritional deficiency, inflammation, autoimmune disease, traction, and scalp disorders can all contribute. More than one cause may be present.

Pattern hair loss is common in both sexes. Men more often notice recession at the temples, thinning at the crown, or both. Women more often notice a widening center part, reduced ponytail density, or diffuse thinning over the top of the scalp while the frontal hairline is relatively preserved.

WHY EARLY EVALUATION MATTERS

Treatment is usually most useful while follicles remain present but miniaturized. A clinical scalp examination, history, photographs, and selected laboratory testing can help distinguish pattern loss from excessive shedding, autoimmune loss, traction, or a scarring process.

SCHEDULE PROMPT EVALUATION FOR

- Sudden or rapidly increasing shedding.
- Round or sharply defined bald patches.
- Scalp pain, burning, itching, scale, pustules, or drainage.
- A shiny scalp or loss of follicle openings, which may suggest scarring.
- Hair loss with fatigue, menstrual changes, acne, new facial hair, unexplained weight change, or systemic symptoms.
- Hair loss after pregnancy, illness, surgery, major stress, or rapid weight loss.

Hair Loss *in Men*

Six realistic presentations showing how recession and thinning can involve different regions of the scalp.

1 **Full-density reference** A comparison image; natural hairlines still vary.	2 **Early temple recession** Subtle movement at both corners of the frontal hairline.
3 **Frontal / M-shaped recession** Deeper temple loss with a central forelock remaining.	4 **Vertex or crown thinning** Scalp becomes visible around the natural crown whorl.
5 **Combined frontal + crown loss** The bridge between the two areas becomes less dense.	6 **Advanced pattern loss** Top coverage is greatly reduced while side/back donor hair remains.

Illustrative clinical-style images. Lighting, hair color, length, texture, and styling can change how much scalp is visible.

Reading the *Male Pattern*

The location, speed, symptoms, and donor-area quality matter as much as the amount of visible loss.

TYPICAL MALE PATTERN

Frontal/temporal: The corners recede and the hairline may become M-shaped. A mature hairline can be stable; continuing miniaturization and serial-photo change suggest progression.

Vertex/crown: Density decreases around the whorl. Bright overhead light or wet hair may reveal it before it is obvious in a mirror.

Diffuse patterned thinning: The entire top may lose caliber and density without a sharply bald crown.

Advanced: Frontal and crown areas can join, leaving stronger hair around the sides and back. The Norwood-Hamilton scale describes extent, but does not determine cause, follicle viability, or treatment.

PATTERNS THAT NEED A DIFFERENT WORK-UP

- Diffuse shedding from illness, stress, medications, or rapid weight loss.
- Alopecia areata, which may cause smooth round patches.
- Traction or breakage from tight grooming practices.
- Inflammatory, infectious, or scarring scalp disease.
- Hair-shaft breakage rather than loss from the follicle.

WHAT THE CLINICIAN EVALUATES

- Pattern, rate of change, family history, and donor-area density.
- Hair-shaft caliber variation and follicle miniaturization.
- Whether follicular openings remain visible and follicles may still be viable.
- Scalp redness, scale, tenderness, scarring, or infection.
- Medication, hormone, nutrition, and medical history.
- Baseline photographs of the frontal hairline, temples, mid-scalp, crown, and donor region.
- Whether medication, regenerative procedures, transplantation, or combination care is appropriate.

A REALISTIC GOAL

The goal may be to slow further miniaturization, improve the appearance of density, support scalp health, recover hair where follicles remain responsive, or prepare for transplantation. A procedure cannot create unlimited donor hair or promise restoration of youthful density.

Hair Loss *in Women*

Six realistic presentations showing part widening, diffuse crown loss, and frontal or temporal thinning.

1 **Full-density reference** A narrow part with good coverage; normal part width varies.	2 **Mild part widening** The center part begins to look broader or more visible.
3 **Moderate central thinning** Reduced density extends along the part and into the crown.	4 **Diffuse top thinning** Scalp shows across a wider area while the frontal edge may remain.
5 **Frontal / temporal thinning** Reduced density may also involve the front or temples in women.	6 **Advanced diffuse loss** Marked crown visibility without the classic smooth male-pattern bald scalp.

Illustrative clinical-style images. Hair part, color contrast, styling, extensions, and lighting may change the appearance of density.

Reading the *Female Pattern*

A widening part is important—but reproductive history, shedding, symptoms, nutrition, and hormones can change the diagnosis.

TYPICAL FEMALE PATTERN

Part widening: The center part gradually broadens, sometimes creating a triangular or "Christmas-tree" appearance toward the front.

Diffuse crown thinning: Scalp becomes increasingly visible over the top while the frontal edge may remain relatively preserved.

Reduced volume: A thinner ponytail, more scalp visible when hair is wet, and loss of styling fullness may appear before a distinct bald area.

Frontal/temporal involvement: Some women develop temple recession or frontal thinning. Rapid recession, eyebrow loss, redness, scale, or a smooth shiny band warrants prompt evaluation for a scarring process.

Ludwig and Sinclair scales help document extent, but photographs and scales do not establish the cause.

HORMONAL AND LIFE-STAGE CLUES

- Pregnancy or postpartum hormone changes.
- Perimenopause or menopause.
- Irregular cycles, acne, new facial hair, or other possible signs of androgen excess.
- Starting, stopping, or changing hormonal contraception or hormone therapy.
- Rapid weight loss, calorie restriction, or inadequate protein intake.

WOMEN NEED A TAILORED EVALUATION

Treatment selection may depend on pregnancy plans, menstrual and hormonal history, medication use, blood pressure, laboratory findings, and the possibility of an inflammatory or scarring disorder.

Do not assume every widening part is genetic. Telogen effluvium, traction alopecia, frontal fibrosing alopecia, central centrifugal cicatricial alopecia, alopecia areata, thyroid disease, iron deficiency, medication effects, and scalp disease can overlap with female-pattern loss.

WHAT MAY BE DOCUMENTED OR TESTED

- Standardized center-part, frontal, temporal, crown, and side photographs.
- Shedding onset, menstrual/reproductive history, illness, surgery, stress, dieting, and medications.
- Scalp inflammation, follicular openings, breakage, miniaturization, and traction.
- Selected laboratory studies when history suggests iron, thyroid, nutritional, or hormonal contributors.
- Dermatology evaluation or scalp biopsy when loss is unclear, rapidly progressive, inflammatory, or possibly scarring.

A REALISTIC GOAL

Depending on the cause, the plan may focus on correcting a trigger, reducing shedding, stabilizing progression, improving the appearance of density, supporting regrowth from viable follicles, or combining medical and procedural care.

Regenerative and *Medical Care*

A personalized plan starts with the diagnosis, not with a procedure.

EVIDENCE AND REGULATORY NOTE

PRP and microneedling have some clinical evidence for selected patients, but results vary. There are currently no FDA-approved exosome products for treating hair loss. Any biologic or compounded therapy should be discussed with clear attention to product source, sterility, evidence, and risk.

OPTIONS A CLINICIAN MAY DISCUSS

Medical therapy

Topical or oral medication may help selected patients with pattern hair loss. Choice depends on sex, pregnancy potential, medical history, blood pressure, and side-effect profile.

Platelet-rich plasma (PRP)

A concentrated portion of the patient's own blood is injected into the scalp. Multiple sessions and maintenance may be recommended; response is variable.

Microneedling

Controlled micro-injury may be used alone or alongside selected therapies. Sterile technique and appropriate depth are important.

WHAT TREATMENT CANNOT PROMISE

- Guaranteed regrowth, a specific percentage of density, or a fixed timeline.
- Revival of follicles that are permanently scarred or no longer present.
- Correction of an untreated hormonal, nutritional, inflammatory, or autoimmune cause.
- Permanent results without maintenance when the underlying loss is progressive.

HOW PROGRESS IS FOLLOWED

- Standardized photographs with the same lighting, part, and hair length.
- Scalp symptoms, shedding rate, part width, and perceived density.
- Tolerance, adherence, side effects, and laboratory monitoring when indicated.
- Formal reassessment before adding procedures or changing the plan.

Regenerative Care *vs. Hair Transplant*

These approaches solve different problems and may sometimes be used together.

	REGENERATIVE / NONSURGICAL CARE	HAIR TRANSPLANT
PURPOSE	Support existing miniaturized follicles, scalp health, or stabilization in selected patients.	Redistribute permanent donor follicles into areas of loss.
BEST FIT	Often earlier thinning where follicles remain viable; depends on diagnosis.	Selected patients with stable loss and adequate donor supply.
DOWNTIME	Usually limited, but varies by procedure.	Surgical recovery with temporary swelling, crusting, redness, and restrictions.
RESULTS	Gradual and variable; may require a series and maintenance.	Growth develops over months; density depends on graft survival and donor supply.
LIMITATIONS	Cannot reliably restore advanced bald areas without viable follicles.	Does not stop continuing loss in non-transplanted hair and cannot create unlimited donor hair.
RISKS	Pain, redness, swelling, infection, scarring, and therapy-specific risks.	Bleeding, infection, scarring, altered sensation, poor growth, or unnatural design.

QUESTIONS TO ASK BEFORE DECIDING

- What is my diagnosis and is the loss scarring or non-scarring?
- What improvement is realistic for my current pattern?
- If I may need a transplant later, how does this plan preserve donor supply?
- Are the follicles in the treatment area still viable?
- What maintenance will I need after treatment?
- What alternatives, risks, total costs, and follow-up are involved?

Building Your *Hair-Restoration Plan*

The best plan is individualized to the cause, pattern, stage, health history, and goals.

YOUR VISIT MAY INCLUDE

- Detailed history of onset, shedding, symptoms, family pattern, styling, nutrition, illness, medications, and hormones.
- Scalp and hair examination, pattern classification, and standardized photographs.
- Review of prior treatments and the results or side effects you experienced.
- Targeted laboratory testing or dermatology referral when clinically indicated.
- A staged plan with measurable goals and scheduled reassessment.

BRING TO YOUR VISIT

- A current medication and supplement list.
- The dates of major illness, surgery, childbirth, weight change, or new medications.
- Photos showing your hairline, part, or crown before the change, if available.
- A list of products and treatments you have already tried.

This guide is educational and does not replace diagnosis or individualized medical advice.

CONTACT VIVIER PROMPTLY IF

- Loss becomes sudden, patchy, painful, inflamed, or associated with scalp drainage.
- A treatment causes facial swelling, hives, trouble breathing, fainting, fever, or rapidly spreading redness.
- You become pregnant or your pregnancy plans change while using a medication that may not be appropriate in pregnancy.

OUR APPROACH

Vivier evaluates hair loss in women and men. We use pattern recognition, clinical history, scalp findings, and appropriate testing to build a plan focused on preserving hair, supporting density where possible, and setting honest expectations.

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Discuss your hair and scalp with *your Vivier clinician.*

(201) 475-4091
19–21 FAIR LAWN AVE, FAIR LAWN, NJ 07410