CLINICAL PROTOCOL

The Hair Loss Protocol

Slow, stop, and in many cases reverse pattern hair loss, using the treatments that actually have evidence behind them.

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Most hair loss in men and women is **androgenetic alopecia** (pattern hair loss). It is driven by a hormone called DHT (dihydrotestosterone) acting on genetically susceptible follicles, which shrink a little more with each growth cycle until they stop producing visible hair. The single most important idea in this protocol is this: **you are defending the follicles you still have.** Treatment protects and revives miniaturizing follicles far more easily than it resurrects ones that are already gone, so starting earlier beats starting later, every time.

IMPORTANT: PLEASE READ FIRST

This is education, not medical advice. It is designed to help you and your physician work together, not to replace a clinician who knows your history. Confirm your diagnosis before treating: not all hair loss is pattern hair loss.

Do not start or stop any medication on your own. **Finasteride and dutasteride must not be taken or handled by women who are pregnant or may become pregnant** (risk of birth defects). **See a dermatologist promptly for sudden patchy loss, or a red, scaly, itchy, or scarring scalp**, these can signal alopecia areata or scarring alopecia, which are different diseases and can cause permanent loss if untreated.

Know what you are treating

Pattern hair loss is a DHT problem playing out over years. The facts below frame every decision that follows.

The driver	DHT, made from testosterone by the enzyme 5-alpha-reductase, shrinks susceptible follicles over time
The pattern	Men: hairline and crown. Women: diffuse thinning over the top, with the frontal line usually preserved
The window	Earlier treatment saves more follicles. Long-dormant, fully bald areas respond the least
The commitment	These treatments work while you use them. Stop, and the loss resumes over the following 6 to 12 months

STEP 1 Confirm the diagnosis and rule out reversible causes

Before you commit to years of treatment, make sure you are treating the right thing. Some common causes of shedding are fully reversible once corrected.

- [ ] **See a clinician or dermatologist** to confirm pattern hair loss versus telogen effluvium (a temporary shed after illness, surgery, childbirth, crash dieting, or stress), alopecia areata, or a scarring alopecia.
- [ ] **Check the correctable labs:** ferritin and iron studies, thyroid function (TSH), and vitamin D. Low iron and thyroid problems are common, treatable drivers of shedding, especially in women.
- [ ] **Review your medications and diet:** crash diets and very low protein intake starve the follicle. Some drugs cause shedding.

> **Sudden round bald patches, or a red, scaling, painful, or scarring scalp, are not pattern hair loss.** See a dermatologist quickly. Scarring alopecia can become permanent if it is not treated early.

STEP 2 Start the two treatments with the strongest evidence

Minoxidil and finasteride are the FDA-approved, best-studied treatments for pattern hair loss. Used together they work on two different mechanisms and outperform either alone. Discuss suitability and side effects with your physician.

TREATMENT	TYPICAL USE	WHAT IT DOES & WHAT TO KNOW
Minoxidil (topical 5%)	Applied to the scalp daily (women often 2% or 5%). An oral low-dose form exists by prescription.	Prolongs the growth phase and thickens hairs. Works for men and women. Expect an *initial shed* in the first weeks as follicles reset, this is normal. You must keep using it to keep the gains.
Finasteride (oral 1 mg/day)	Once daily, for men. Prescription only.	Blocks 5-alpha-reductase and lowers DHT, attacking the root cause. Strong evidence for halting loss and partial regrowth. Possible sexual side effects in a minority. **Not for women who are or may become pregnant.**

STEP 3 Add evidence-backed adjuncts

These stack on top of Step 2 for extra benefit, or serve as options for people who cannot or prefer not to use the prescription drugs. Each links to my full review of the science.

ADJUNCT	HOW TO USE IT	WHY IT HELPS
Microneedling	A dermaroller/dermastamp session, spaced out, on days you are not applying minoxidil.	Controlled micro-injury triggers growth signaling and clearly **boosts the response to minoxidil** in trials.
Red light / low-level laser (LLLT)	An FDA-cleared home cap or comb, used on a regular schedule.	Red and near-infrared light supports follicle energy metabolism and can modestly increase density. See my wavelength breakdown.
Saw palmetto	A standardized oral extract, or a topical formulation.	A natural, milder 5-alpha-reductase inhibitor. Weaker than finasteride, but an option for those who want a natural route.
Ketoconazole 2% shampoo	Used as a shampoo a few times per week.	Anti-inflammatory and mildly anti-androgenic at the scalp. A cheap, low-risk add-on.

STEP 4 Build the foundation the follicle needs

Drugs and devices work better on a well-supplied follicle. These do not replace Step 2, but they remove the brakes.

- [ ] **Protein:** hair is mostly protein. Eat enough, and do not crash diet, which reliably triggers shedding.
- [ ] **Correct deficiencies, do not megadose:** fix low iron (ferritin), thyroid, and vitamin D if they are low. Supplementing nutrients you are *not* low in does not help and can occasionally harm.
- [ ] **Sleep and stress:** chronic stress pushes follicles into shedding. Protect your sleep.

Stack it for the best result

The people who do best rarely rely on one thing. A common evidence-based stack looks like this.

- [ ] **Core:** topical minoxidil, plus oral finasteride for men (with your doctor).
- [ ] **Amplify:** add microneedling to boost the minoxidil response, and a red light device on a regular schedule.
- [ ] **Support:** ketoconazole shampoo a few times a week, and a solid nutritional foundation.

Read the head-to-head evidence in my comparison of minoxidil, finasteride, and dutasteride and the broader effectiveness meta-analysis.

What to expect, and when

Hair grows slowly. Judge results on the calendar below, not week to week.

Weeks 2 to 8	A temporary shed with minoxidil is common and is a sign it is working, not failing
Months 3 to 6	Shedding slows. Early signs of finer regrowth and less fall in the shower
Months 6 to 12	The honest assessment point. Compare standardized photos to your baseline
Ongoing	Benefits last only while you continue. Take a baseline photo today to track progress

If you want more, or you are further along

When the first-line stack is not enough, these are the next conversations to have with a specialist.

- [ ] **Dutasteride** — a more potent DHT blocker than finasteride, used off-label for hair loss under specialist care.
- [ ] **Platelet-rich plasma (PRP)** — in-office injections of your own concentrated platelets; a reasonable adjunct with supportive evidence.
- [ ] **Hair transplant** — for areas that are already bald and will not respond to medication. Keep treating the rest of the scalp so the transplant does not sit on a receding background.

A note for women

Female pattern hair loss is real and treatable, but the workup differs. Topical minoxidil is first-line and effective. Oral anti-androgens (such as spironolactone) are used under a doctor's care instead of finasteride. Because low iron, thyroid disease, and hormonal shifts (including menopause) are common contributors, the lab workup in Step 1 matters even more. See my guide to hair disorders around menopause.

Stay curious, stay skeptical, stay healthy.

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