

HAIR RESTORATION · ASSESSMENT

Hair loss: what to check first

The first step in hair loss is a diagnosis, not a treatment. Pattern, history and, where indicated, blood work identify the cause before any scalp treatment is chosen.

KEY FACTS

Most common cause	Androgenetic alopecia (pattern hair loss), driven by follicle sensitivity to DHT.
Other common causes	Telogen effluvium (shedding after a trigger), alopecia areata (autoimmune, patchy), low iron stores, low vitamin D, thyroid disturbance.
First step	A diagnosis, not a treatment: history, scalp examination and, where indicated, a blood panel before anything is chosen.
Blood panel	Usually ferritin (iron stores), vitamin D, zinc and thyroid function, with other tests added according to history.
Not interchangeable	Alopecia areata needs different management from pattern hair loss; telogen effluvium is managed mainly by removing the trigger.
Who assesses	Dr Sin Yong personally, Orchard Road, Singapore. Extensive alopecia areata and surgical hair restoration are referred on.

Why diagnosis comes before any treatment

Hair loss is a symptom with a long list of causes, and several of them are general medical conditions rather than scalp conditions. Treating the scalp before working through that list means treating a symptom without a diagnosis. A woman with thyroid-driven shedding who is sold a course of scalp treatments keeps shedding, and the conclusion drawn is that her hair loss is “stubborn”. A woman with post-partum shedding, in which follicles are resting rather than lost, may credit whatever she happened to be paying for when the recovery that was coming anyway arrives.

“If nobody ordered blood work before recommending a treatment, the assessment is incomplete.”

Dr Sin Yong

The common causes

CAUSE	WHAT IS HAPPENING	WHAT IT TENDS TO LOOK LIKE
Androgenetic alopecia (pattern hair loss)	Genetic sensitivity to DHT gradually miniaturises follicles. Progressive, so some form of maintenance is usually needed.	Men: receding temples and crown thinning (Norwood scale). Women: diffuse thinning over the crown and a widening parting, with the frontal hairline usually preserved (Ludwig scale).
Telogen effluvium	A synchronised shift of many follicles into the resting phase after a trigger: childbirth, illness, fever, surgery, crash dieting, major stress. Follicles are resting, not dead.	Heavy, diffuse shedding from everywhere, typically starting two to four months after the trigger, which is why the connection is easily missed. Often self-limiting once the trigger is corrected, but it can become chronic.
Alopecia areata	Autoimmune suppression of follicles. The follicle survives, so regrowth is possible; relapse is part of the condition.	Smooth, well-defined patches. Extensive or rapidly spreading disease is referred to dermatology.
Nutritional and systemic	Low ferritin (iron stores), low vitamin D, low zinc, thyroid disturbance in either direction, hormonal conditions such as PCOS, hormonal transitions around menopause.	Usually diffuse thinning or shedding. Invisible on scalp examination; found only on a blood test. True biotin deficiency is uncommon.

The three-step assessment

- History first. When the shedding started, what happened in the months before it, pregnancies, diet, medications, general health and the family pattern.
- Examination second. The distribution of loss, the state of the hairline, the calibre of the hairs and the scalp itself.
- Blood work third, where history and examination point to it. A diffuse shedding pattern with a suggestive history makes laboratory screening part of basic diligence. No scalp camera sees a ferritin level and no treatment device measures thyroid function.

Only after those three steps does treatment selection mean anything. Correcting a deficiency does not treat pattern hair loss on its own, but an uncorrected deficiency can limit the response to any treatment. Recent results from your own GP count: bring them rather than repeating tests unnecessarily.

Before your visit: a self-check to bring along

- When did it start, and was it gradual or sudden?
- What happened two to four months before the shedding began? Childbirth, illness or fever, surgery, a crash diet, a new medication, a very stressful period.
- Where is the loss? A widening parting with a preserved hairline suggests pattern loss; shedding evenly from everywhere suggests a systemic cause; patches suggest something else again.
- Scalp symptoms? Itch, pain, scaling or redness change the assessment.
- Family pattern: hair thinning in parents or siblings, and at what age.
- Medicines and supplements you take, and any recent blood results (ferritin, vitamin D, thyroid) from your GP.
- For women: pregnancies, breastfeeding, contraception, menstrual changes, and any diagnosis such as PCOS or thyroid disease.
- What you have already tried, for how long, and what happened when you stopped.

Men and women lose hair differently

Male and female pattern hair loss are the same underlying condition, but they look different and are assessed differently. In men, the hairline recedes at the temples and the crown thins. In women, thinning is diffuse over the crown, the parting widens and the ponytail slims, while the frontal hairline usually holds. Grading a woman on the male scale usually misdescribes what is happening. The list of possible causes is also longer in women, which is why blood work carries more weight in a female assessment, and some oral medicines used for male pattern hair loss are not used in women who are pregnant or could become pregnant.

The treatment landscape, briefly

Once a diagnosis supports it, options for pattern hair loss include low-level laser therapy (photobiomodulation), topical or oral medical therapy where suitable, injectable procedures such as platelet-rich plasma when the plan calls for more support, and nutritional correction where a deficiency was found. Medical therapy for pattern loss must be used continuously; stopping it leads to rebound shedding. Telogen effluvium is managed mainly by identifying and removing the trigger. Alopecia areata follows its own pathway, with extensive disease referred to dermatology. Surgical hair restoration is considered when pattern loss has stabilised and there is enough donor hair; suitable patients are referred for surgical assessment, and medical management usually continues afterwards. Response varies with the cause, the duration of loss and the state of the follicles, which is why it is assessed individually rather than promised in advance.

Pregnancy and breastfeeding

Oral and topical hair-loss medications are not recommended during pregnancy. Low-level laser is a drug-free option that may be considered after assessment, although formal safety data in pregnancy are limited. Scalp injections are usually deferred until after pregnancy.

When to see a doctor

- Shedding that is consistently heavy, or that has continued well beyond a known trigger.
- A visibly widening parting, a persistently slimmer ponytail, or thinning you can see at the temples or crown.
- Loss in patches, or scalp symptoms such as itch, pain or scaling.

Earlier assessment is generally more useful than later, because follicles that are thinning respond differently from follicles that have long stopped producing. A single consultation can establish which situation applies.

NEXT STEP

Consultations with Dr Sin Yong are by appointment at Orchard Road, Singapore. WhatsApp a short note on your concern to +65 8023 7170 (replies within clinic hours: Mon–Fri 10am–8pm, Sat 11am–3pm). Every assessment is carried out personally; options explained include waiting, no treatment or referral.

SOURCES

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