Hair Loss Medications in 2026

A complete patient guide to what is available now, what is used off-label, what is natural, and what is still in trials. Whether you are just beginning to notice thinning or have been managing hair loss for years, this guide offers a clear, honest, and evidence-based overview of where treatment stands today.

UPDATED APRIL 2026 PATIENT GUIDE

Contents

A comprehensive guide to hair loss medications, evidence, and emerging treatments in 2026.

Understanding the Landscape

Hair loss treatment has improved a great deal, but the single most important thing to understand is that **there is no medication that suits every type of hair loss**. Pattern hair loss, alopecia areata, telogen effluvium, traction alopecia, and scarring alopecias each behave differently and require different approaches. In 2026, the field is more differentiated than ever, with treatments now targeting specific biological pathways such as androgen signaling, immune dysregulation, follicle stem cell dormancy, and prolactin receptor biology. The era of one-size-fits-all hair loss treatment is definitively over.

This guide is written for patients who want a clear, honest overview of everything currently available. It covers medicines already on the market, commonly used off-label treatments, natural options with real evidence behind them, and the most relevant drugs still being tested in human trials as of April 2026. The goal is to help you walk into a medical consultation better informed — not to replace that consultation.

FDA-Approved Treatments

Proven, regulated therapies with robust clinical evidence for specific diagnoses.

Off-Label Treatments

Widely used by specialists beyond their approved indication, with growing evidence bases.

Natural Options

Some have real human data. Others are oversold. This guide separates the two honestly.

Investigational Drugs

Exciting pipeline candidates in human trials — promising, but not yet available standards of care.

First Things First: What Kind of Hair Loss Do You Have?

The best medication depends entirely on the diagnosis. A treatment that makes perfect sense for androgenetic alopecia may be the wrong choice entirely for telogen effluvium, and a patient with active scarring alopecia may need urgent anti-inflammatory care rather than a standard growth-stimulating product. That is why a proper assessment matters before anything else.

Pattern Hair Loss (Androgenetic Alopecia)

The most common hereditary form, linked to follicle miniaturisation and androgen sensitivity. It affects roughly 50% of men by age 50 and up to 40% of women by menopause. Responds well to minoxidil and DHT-reducing strategies. The Hamilton-Norwood scale is used to grade severity in men, and the Ludwig scale is used for women.

Alopecia Areata

An immune-mediated condition that causes patchy or more extensive hair loss, sometimes progressing to total scalp or body hair loss. It affects about 2% of the global population at some point in their lifetime, can be triggered or worsened by stress, and severity ranges from small patches to alopecia totalis or universalis. JAK inhibitors have transformed treatment for severe cases.

Telogen Effluvium

A shedding disorder that often follows illness, stress, hormonal change, weight loss, medication triggers, or nutritional deficiencies. Shedding typically peaks 2–3 months after the triggering event, and most cases resolve within 6–9 months once the trigger is addressed. Chronic telogen effluvium lasting over 6 months is a distinct entity, and the priority is usually identifying and correcting the trigger — not jumping to hair medications.

Traction Alopecia

Caused by chronic tension on the hair from tight styles or extensions. It is particularly prevalent in communities where tight braiding, weaves, or extensions are common. Can sometimes improve if the damaging tension is stopped early, but long-standing cases may become permanent, so early intervention is key as follicle damage becomes irreversible over time.

Scarring Alopecias

Inflammatory conditions that can permanently destroy follicles if not treated promptly. Examples include lichen planopilaris, frontal fibrosing alopecia, and discoid lupus erythematosus. These require medical treatment aimed at suppressing inflammation, and biopsy is often required for definitive diagnosis rather than simply boosting growth.

A treatment that helps one type of hair loss can be ineffective or even harmful for another. Always confirm your diagnosis with a qualified clinician before starting any hair loss medication.

Minoxidil: The Most Accessible Starting Point

What It Does

Minoxidil works as a **growth stimulant**. It can extend the active growth phase of hair follicles and increase blood flow to the scalp. It was originally developed as an oral antihypertensive drug, and its hair-growth effect was discovered as a side effect. It is thought to work partly by opening ATP-sensitive potassium channels in follicle cells, helping prolong the anagen (growth) phase.

It is not a cure for the underlying cause of pattern hair loss — it does not switch off the miniaturisation process — but it can meaningfully slow shedding and stimulate regrowth for many patients. Topical minoxidil remains one of the most established first-line treatments for pattern hair loss. It is accessible without a prescription in many forms, does not directly alter hormones, and has decades of real-world use behind it.

What to Expect

Patience is essential. The official consumer labeling notes that visible benefit can take several months, and **ongoing use is needed to maintain results**. Many patients experience an initial shedding phase in the first few weeks — this is normal and reflects the follicle cycle resetting, not a sign the treatment is failing. This early telogen effluvium typically lasts 2–8 weeks and affects roughly 10–15% of users.

Because minoxidil does not address androgen sensitivity, it is very commonly combined with other treatments in clinical practice. For patients whose follicles are highly androgen-sensitive, minoxidil alone may slow progression without fully halting it. Combination with a DHT-reducing strategy often produces better long-term results. For most patients, results plateau after 12–18 months.

Forms Available

- Topical solution or foam (2% and 5%)
- Low-dose oral minoxidil (0.25–5 mg daily, off-label)
- Compounded formulations combining minoxidil with other actives (e.g., tretinoin, finasteride)
- The 5% foam formulation is generally preferred for ease of use and reduced scalp irritation

Finasteride and Dutasteride: Targeting the Root Cause in Men

For male pattern hair loss, antiandrogen strategies — specifically 5-alpha reductase inhibitors — target one of the core biological drivers: the conversion of testosterone to dihydrotestosterone (DHT). DHT binds to androgen receptors in genetically susceptible follicles, triggering a progressive miniaturisation cycle that shortens the anagen phase with each successive cycle until the follicle produces only vellus (fine, colorless) hairs or stops producing hair entirely. Reducing DHT levels addresses the cause rather than just stimulating growth on top of an ongoing process.

Finasteride 1 mg

Finasteride 1 mg oral is an FDA-indicated prescription treatment for male pattern hair loss. Typical dosing is 1 mg daily. It works by blocking the enzyme that converts testosterone to DHT, and clinical trials show it can reduce DHT levels by approximately 70%. Continued treatment is generally required to maintain benefit — stopping usually results in gradual reversal of gains.

Across studies, finasteride stabilizes hair loss in about 83% of men and produces visible regrowth in about 66% over 2 years. Patients should be properly counseled about possible adverse effects, including sexual side effects, and about the need for medical review if mood changes occur. Importantly, the 2025 EMA update confirmed suicidal ideation as a recognized side effect of finasteride tablets, and this should be discussed explicitly at prescribing, reinforcing the importance of careful prescribing and monitoring rather than casual internet self-treatment.

Dutasteride

Dutasteride is often viewed as the stronger cousin of finasteride. It inhibits both type I and type II 5-alpha reductase enzymes, whereas finasteride only inhibits type II, which is why dutasteride typically reduces DHT by approximately 90–95%. It is approved for androgenetic alopecia in some markets including Japan and South Korea. In many countries, it is still used off-label for hair loss but is increasingly part of specialist practice.

Recent meta-analyses confirm that dutasteride is generally more potent than finasteride for androgenetic alopecia, but that does not automatically make it the best starting point for every patient. Its half-life of approximately 5 weeks means it persists in the body much longer than finasteride, which has implications for side effect duration and is particularly relevant for men considering future fertility.

Topical Finasteride

Topical finasteride, used alone or combined with minoxidil, has emerged as an option that may reduce systemic DHT exposure compared with oral finasteride. Several studies have shown meaningful scalp DHT reduction and improvements in hair density, making it an increasingly common choice among specialists who want to minimise systemic side effect risk while still targeting the androgen pathway.

⚠ Finasteride and dutasteride are not indicated for women who are pregnant or may become pregnant. Both carry serious reproductive risks. In women, these medications require careful specialist supervision, pregnancy avoidance, and individualized risk-benefit analysis.

JAK Inhibitors: A Breakthrough for Alopecia Areata

For patients with severe alopecia areata, the arrival of JAK inhibitors represents the most significant treatment advance in decades. These are systemic immune-modulating therapies that work by blocking Janus kinase enzymes — including JAK1, JAK2, JAK3, and TYK2 — which are part of the JAK-STAT signaling pathway, a key driver of the autoimmune attack on hair follicles in alopecia areata. By interrupting this pathway, they can help restore immune privilege to the follicle and allow regrowth. For the right patient, they can be genuinely life-changing.

Three JAK inhibitors have now received FDA approval specifically for severe alopecia areata. Each has a slightly different approved population and profile:

1

Baricitinib

Approved for adults with severe alopecia areata. A JAK1/JAK2 inhibitor with clinical trial data showing meaningful scalp hair regrowth in a significant proportion of participants with severe or total hair loss. In the BRAVE-AA1 and BRAVE-AA2 phase 3 trials, approximately 35–40% of patients achieved a SALT score ≤20 — meaning at least 80% scalp hair coverage — at 36 weeks. It is taken as a once-daily oral tablet.

2

Ritlecitinib

Approved for adults and adolescents aged 12 and over, making it the only approved option available to younger patients. The ALLEGRO phase 2b/3 trial showed meaningful regrowth responses. A selective JAK3/TEC family kinase inhibitor, its selectivity is thought to offer a more targeted immune profile.

3

Deuruxolitinib

Approved for adults with severe alopecia areata. The most recent approval, with strong phase 3 data from the THRIVE-AA1 and THRIVE-AA2 trials showing approximately 30–40% of patients achieving SALT ≤20 at 24 weeks. The 12 mg twice-daily dose showed particularly strong responses in patients with alopecia totalis or universalis.

All three medications require baseline screening — including tuberculosis, hepatitis, and blood counts — as well as ongoing monitoring during treatment. None should be used in pregnancy.

Off-Label Treatments Commonly Used by Specialists

Off-label prescribing is a normal and legal part of medical practice, particularly in dermatology. "Off-label" means a drug is being used outside its officially approved indication — not that it is experimental or dangerous. Many of the most widely used hair treatments today fall into this category, supported by growing evidence but not yet carrying formal approval for hair loss.

Low-Dose Oral Minoxidil

One of the fastest-growing off-label treatments in specialist hair medicine. Not FDA-approved specifically for hair loss, but now used widely because it can be more convenient than daily topical application for some patients. Typical doses range from 0.25 mg to 2.5 mg daily in women and 1.25 mg to 5 mg daily in men. A 2025 international consensus statement in *JAMA Dermatology* reflected just how mainstream this approach has become in specialist practice, and recommended pre-treatment cardiovascular screening before starting therapy.

It is important to note that off-label does not mean risk-free. Oral minoxidil can cause unwanted body or facial hair growth, fluid retention, and cardiovascular symptoms in some patients. Hypertrichosis is the most commonly reported side effect and can affect a meaningful proportion of women at higher doses. A 2024 randomized trial found that oral minoxidil 5 mg daily was not superior to topical 5% minoxidil in men, though it showed broadly similar efficacy and remains a reasonable option for selected patients after proper screening.

Spironolactone (Women)

For women with pattern hair loss, spironolactone remains one of the most commonly prescribed antiandrogen options. Typical doses for hair loss range from 50–200 mg daily. It works by blocking androgen receptors and reducing adrenal androgen production, making it especially relevant when there are clinical or biochemical signs of androgen excess — acne, seborrhea, irregular periods, or polycystic ovary syndrome. Australian guidance and multiple international reviews continue to place it alongside minoxidil as a core pharmacologic option in female pattern hair loss.

Because it can affect electrolytes and blood pressure, spironolactone requires monitoring of potassium levels and blood pressure. It is contraindicated in pregnancy and requires reliable contraception in women of childbearing age.

Finasteride or Dutasteride in Women

In selected women, specialist prescribers may use finasteride or dutasteride off-label. Postmenopausal women are the most common candidates. Some specialists use finasteride 1–2.5 mg or dutasteride 0.5 mg. These are not casual first-line choices. Reproductive safety, mandatory pregnancy avoidance, and careful individualized risk-benefit thinking are essential.

Evidence in women is more limited than in men, but it is growing, particularly for postmenopausal female pattern hair loss. These medicines can be appropriate in certain cases — particularly postmenopausal women or those with clear androgen excess — but only as part of a carefully supervised medical plan.

Corticosteroids for Patchy Alopecia Areata

Even in the JAK inhibitor era, corticosteroids remain a standard part of care for localized or limited alopecia areata. Intralesional triamcinolone acetonide, typically 5–10 mg/mL injected every 4–6 weeks, is the most widely used approach for limited patches. Topical superpotent corticosteroids such as clobetasol are an alternative for patients who cannot tolerate injections.

Systemic corticosteroids are sometimes used short-term for rapidly progressing disease. These remain important tools for patients with small or localized disease who do not meet the threshold for systemic JAK therapy.

Ketoconazole Shampoo

Ketoconazole shampoo is not a primary regrowth treatment, but it can be a useful adjunct when dandruff, seborrheic dermatitis, scalp irritation, or scalp inflammation are contributing to the picture. It is typically used 2–3 times per week. Some small studies suggest it may have mild antiandrogen properties at the scalp level.

It is best used as an adjunct to primary therapy rather than a standalone treatment for progressive pattern hair loss.

Natural Options: What Has Evidence and What Is Oversold

Patients frequently ask about natural alternatives, and that is a completely reasonable question. The honest answer is that some natural options do have real human data behind them — but the quality and consistency of that evidence varies enormously, and no natural product comes close to the evidence base for minoxidil or finasteride in progressive androgenetic alopecia. The key is not to treat all "natural" products as equal, and not to reject them all either.

Rosemary Oil

The best-known natural option, rosemary oil has the key 2015 study by Panahi et al., which compared rosemary oil with 2% minoxidil over 6 months in men with androgenetic alopecia and found comparable hair count increases. The proposed mechanism includes improved scalp circulation and possible mild inhibition of 5-alpha reductase. It is typically applied topically, diluted in a carrier oil, and scalp irritation is the most common side effect.

Evidence quality is moderate, but this remains one of the few natural treatments with a proper comparative human trial. It is often appealing to patients who prefer topical non-pharmaceutical options.

Pumpkin Seed Oil

Pumpkin seed oil has controlled human data in both men and women showing modest benefits for hair count and density. A 2014 randomized controlled trial in men reported a 40% increase in hair count versus 10% in the placebo group after 24 weeks, and a 2023 study in women also showed positive results.

The proposed mechanism involves mild inhibition of 5-alpha reductase. The dose used in trials is typically 400 mg daily as an oral supplement. The evidence is real but limited in scale — useful as a supportive option, particularly in mild cases, but not a substitute for proven therapies in progressive loss.

Topical Melatonin

Topical melatonin is an emerging supportive option, with small trials suggesting benefit in early hair-loss settings. A 0.1% topical melatonin solution applied nightly has been studied in this context, and a 2004 study showed reduced hair loss in women with androgenetic alopecia or diffuse hair loss.

It is thought to act as an antioxidant, protecting follicles from oxidative stress, and may also directly influence the hair cycle via melatonin receptors in follicle cells. The evidence base is smaller than for rosemary oil or pumpkin seed oil, but early trial data is encouraging enough to warrant attention, particularly for use alongside other therapies.

Saw Palmetto

Saw palmetto continues to attract interest because of its proposed mild antiandrogen effect. It is typically used as an oral supplement at 160–320 mg of standardized extract daily, or in topical formulations. The 2026 study referenced used a proprietary extract at 300 mg daily.

It is generally well tolerated. The proposed mechanism involves inhibition of 5-alpha reductase type I, which is different from finasteride's primary target, type II. The broader evidence base remains substantially less consistent than for finasteride or minoxidil, so it may be worth considering in mild cases or as a supportive supplement, but it should not be positioned as an equivalent to prescription therapy.

> Natural treatments may help some patients, especially in mild cases or as part of a broader program — but they are generally best viewed as **supportive options**, not full replacements for evidence-based medical therapy in clearly progressive androgenetic alopecia.

The Pipeline: Drugs Still in Clinical Trials

This is the section many patients are most curious about — and for good reason. There are several genuinely exciting candidates in development. However, it is important to view all of them as **investigational**: not yet available as standards of care, not yet fully characterized for long-term safety, and not accessible outside of clinical trial settings or compassionate use programs.

1 Pyrilutamide (KX-826)

A topical androgen receptor antagonist applied directly to the scalp, designed to block DHT's effect at the follicle level without significant systemic absorption. In March 2026, Kintor reported that the phase III stage of its pivotal China study met its primary endpoint — statistically significant and clinically meaningful improvement. That result is a major milestone, and Western regulatory submissions are anticipated to follow if the data holds up in broader populations.

2 GT20029

One of the most conceptually novel next-generation candidates. PROTAC (Proteolysis Targeting Chimera) technology represents a fundamentally new approach: rather than simply blocking the androgen receptor, it recruits cellular machinery to physically degrade it. In theory, that could produce more complete and durable androgen receptor suppression than traditional antagonists. The 2025 phase 2 data showed statistically significant improvements in hair density with a favorable tolerability profile.

3 PP405 (Pelage)

A completely different mechanism: instead of targeting DHT or androgen signaling, PP405 is designed to reactivate dormant hair follicle stem cells by targeting the Wnt signaling pathway. This is particularly exciting because it could theoretically work even in follicles that have been miniaturized for years. Pelage reported meaningful phase 2a hair density improvements in 2025 and has positioned the drug as a regenerative approach for androgenetic alopecia in both men and women — an important distinction from most current therapies.

4 HMI-115

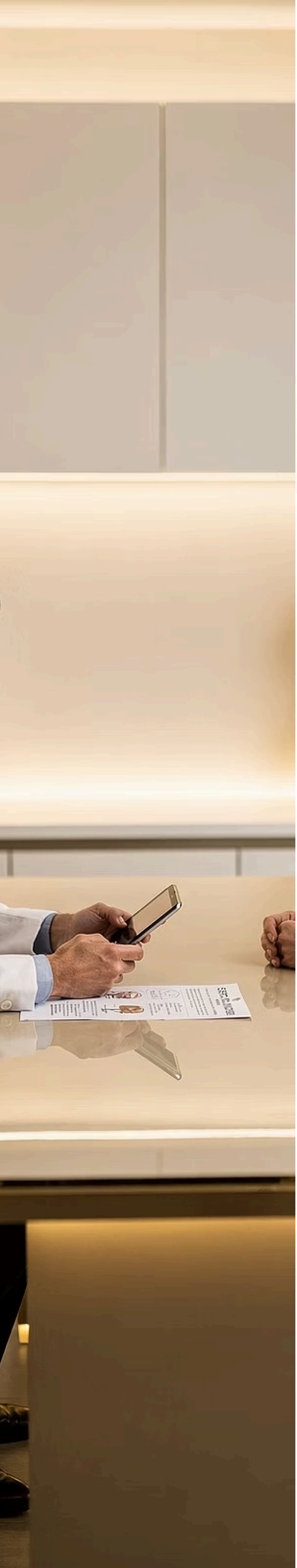
Prolactin has been identified as a negative regulator of hair growth, with elevated prolactin levels suppressing the anagen phase. HMI-115 is a monoclonal antibody that blocks the prolactin receptor, and early Australian data showed promising hair density improvements. This mechanism is entirely independent of DHT, making it potentially useful for patients who do not respond to antiandrogen strategies. Clinical trial registrations and company updates confirm ongoing human studies in androgenetic alopecia.

5 ABS-201

This AI-designed monoclonal antibody was engineered to target the prolactin receptor with high specificity. The HEADLINE phase 1/2a trial began dosing in late 2025, with interim efficacy data expected in H2 2026. If successful, it would represent both a novel mechanism and a novel drug-design methodology entering the hair loss space.

6 AMP-303 (Amplifica)

AMP-303 is delivered via scalp injection rather than topical or oral routes, and its mechanism targets follicle biology at a cellular level distinct from androgen pathways. Early human signals have been described as encouraging by investigators, but it remains in early-stage development with full phase 2 data pending. It is one of the more closely watched nontraditional candidates in the androgenetic alopecia pipeline.



What This Means for You Right Now

Your diagnosis shapes everything. Here is a plain-language summary of where treatment evidence sits today for each major hair loss type — and what a well-informed starting conversation with your clinician might look like.

Male Pattern Hair Loss

The evidence-backed center of treatment remains **minoxidil plus a DHT-reducing strategy** — finasteride or dutasteride depending on the individual patient and prescriber. In most specialist guidelines, combination therapy is now considered the standard of care because growth stimulation and androgen reduction together typically produce better long-term outcomes than either alone. Topical finasteride is an emerging option for patients concerned about systemic side effects. Patients should also be counseled that treatment is long-term, and stopping usually leads to reversal of gains within 6–12 months.

Female Pattern Hair Loss

Diagnosis should include a hormonal workup — including androgens, thyroid studies, and ferritin — to rule out contributing factors. Minoxidil 5% topical or low-dose oral minoxidil are first-line, and spironolactone 100–200 mg is commonly added in suitable patients. Specialist-led prescribing of finasteride or dutasteride may be appropriate in carefully selected cases after thorough review. Women with PCOS or hyperandrogenism may benefit particularly from antiandrogen strategies.

Alopecia Areata

Localized disease is often managed with corticosteroid approaches alone. For severe alopecia areata, the choice between JAK inhibitors depends on age, severity, and individual patient factors — for example, ritlecitinib is an option for patients aged 12 and older. Response rates vary: not all patients respond, and some who do respond may relapse when treatment stops, so ongoing therapy may be needed for sustained benefit. This is a rapidly evolving area, and patients with extensive or treatment-resistant disease should seek a specialist consultation.

Telogen Effluvium

Medication is often not the primary answer. This is usually a trigger-driven shedding disorder — the priority is identifying and correcting the underlying cause. Common triggers include iron deficiency, with ferritin <30 ng/mL often used by specialists as a threshold of concern, thyroid dysfunction, crash dieting, postpartum hormonal shifts, and major illness. Nutritional optimization — especially iron, zinc, vitamin D, and protein — is often the most important intervention. Hair typically recovers fully within 6–12 months once the trigger is corrected.

Traction / Scarring Alopecia

Early diagnosis is critical. For traction alopecia, the most important intervention is immediate cessation of the damaging hairstyle; topical minoxidil may help in early cases. Long-standing traction alopecia can become permanent. Scarring alopecias require treatment based on the specific subtype to prevent irreversible follicle destruction — not growth-stimulating products. Lichen planopilaris may respond to hydroxychloroquine or JAK inhibitors, while frontal fibrosing alopecia is notoriously difficult to treat and requires specialist management.

⚠ Hair medications work slowly. Most need to be continued to maintain benefit. Stopping too early, switching too frequently, or expecting dramatic transformation from medication alone are the most common reasons patients become disappointed. Set realistic timelines and maintain consistent treatment under medical guidance.

The 2026 Landscape: Grounded Optimism

The 2026 medication landscape for hair loss is more promising than it has ever been. The pipeline is genuinely exciting — topical androgen receptor degradation, stem-cell reactivation, prolactin-receptor biology, and AI-designed antibodies represent real scientific progress beyond the traditional DHT-focused model that has dominated the field for decades. The convergence of AI-assisted drug design, PROTAC protein degradation technology, stem cell biology, and prolactin receptor science means that the next 3–5 years could bring more new approved treatments than the previous two decades combined. For patients who have exhausted older options or who have biologies that do not respond well to minoxidil and finasteride, there is real reason for hope in what is being developed.

At the same time, it is important to stay grounded. For pattern hair loss, **minoxidil and antiandrogen strategies remain the backbone** of treatment in 2026 — they are well understood, widely accessible, and backed by decades of evidence. For severe alopecia areata, **JAK inhibitors are the major breakthrough** of recent years and have already changed outcomes for many patients. For women specifically, 2026 represents a meaningful improvement over prior years — more options, more specialist awareness, and growing evidence for antiandrogen strategies beyond spironolactone. Natural options can be helpful in the right context, but they are generally best used as support rather than substitutes for medical therapy in progressive loss.

→ Get a proper diagnosis first

The type of hair loss determines everything — the medication, the timeline, and the realistic goals of treatment. A trichoscopy or scalp biopsy can be invaluable when the diagnosis is unclear.

→ Match the treatment to the diagnosis

Use evidence-backed therapies for your specific condition. Avoid treatments designed for a different type of hair loss. Using a JAK inhibitor for pattern hair loss, or minoxidil alone for alopecia areata, is unlikely to produce meaningful results.

→ Be patient and consistent

Hair medications work on follicle cycles measured in months. Commit to at least three to six months before evaluating results. Photography every 3 months under consistent lighting conditions is the most reliable way to track progress objectively.

→ Work with a qualified clinician

Especially for prescription medications, JAK inhibitors, or off-label treatments — proper prescribing, monitoring, and follow-up matter significantly for both safety and outcomes. A dermatologist with a subspecialty interest in hair loss (trichologist or hair specialist) will have the most current knowledge of available options.

→ Watch the pipeline with informed optimism

Several new mechanisms are in late-stage trials and may reach the market within the next few years. Stay engaged with your specialist about what new options may become appropriate as the evidence matures. ClinicalTrials.gov is a reliable public resource for finding active trials you may be eligible for.

> The most effective hair loss strategy in 2026 is not the newest drug or the most natural option — it is a **well-matched, properly supervised, consistently applied treatment plan** tailored to your specific diagnosis.

Best Treatment by Diagnosis

Quick treatment guide for patients

Diagnosis	What it usually looks like	Best treatment focus	Common medication options	Key note
Male Pattern Hair Loss	Gradual thinning at the hairline, temples, mid-scalp, or crown	Stimulate growth + reduce DHT impact	Topical minoxidil, low-dose oral minoxidil, finasteride, dutasteride	Minoxidil supports growth, but DHT control is often needed to slow ongoing miniaturisation.
Female Pattern Hair Loss	Widening part, diffuse thinning through the top, reduced density, temple recession	Support growth + assess hormonal and internal drivers	Topical minoxidil, low-dose oral minoxidil, spironolactone; selected off-label cases may use finasteride or dutasteride under supervision	Female hair loss often needs a broader review of iron, thyroid, hormones, and metabolic factors as well as treatment.
Alopecia Areata	Sudden patchy loss, beard patches, brow loss, or more extensive autoimmune shedding	Calm the immune attack on the follicle	Intralesional corticosteroids, topical corticosteroids, JAK inhibitors in suitable moderate to severe cases	This is not primarily a DHT-driven condition, so pattern-hair-loss medication is usually not the main answer.
Telogen Effluvium	Sudden diffuse shedding, often after illness, stress, surgery, weight loss, blood loss, or hormonal change	Find and fix the trigger	Usually trigger correction first; minoxidil may be used selectively	This is commonly a shedding disorder rather than a miniaturisation disorder.
Postpartum Hair Loss	Heavy shedding within the first year after childbirth	Recovery support + rule out unmasked pattern loss	Observation, nutritional correction where needed, selective minoxidil use when appropriate	Many cases recover, but postpartum shedding can also reveal underlying female pattern thinning.
Traction Alopecia	Hair loss around the frontal hairline, temples, or margins after tight hairstyles or chronic tension	Remove tension early	Reduce traction, treat inflammation where needed, consider minoxidil in selected early cases	Early traction loss may improve, but long-term traction can become permanent.
Scarring Alopecia	Burning, tenderness, redness, scaling, shiny areas, or disappearing follicles	Urgent inflammation control	Corticosteroids, anti-inflammatory or immune-modulating medication, other diagnosis-specific treatment	Early diagnosis matters because follicle destruction can become permanent.
Mixed Hair Loss	A combination such as pattern loss plus shedding, scalp inflammation, postpartum change, or hormonal imbalance	Treat both the trigger and the background thinning	Combination plan based on the diagnoses involved	Many patients have more than one process happening at the same time.

Fast Takeaway for Patients

→ **If your hair loss is mainly pattern-related:** Think minoxidil plus antiandrogen support.

⇨ **If your hair loss is autoimmune:** Think immune-directed treatment, not just growth stimulation.

↘ **If your hair loss is sudden shedding:** Think trigger correction first.

→ **If your hair loss is caused by tight hairstyles or tension:** Think remove the cause early.

→ **If your scalp is inflamed, painful, shiny, or scarred:** Think urgent medical assessment.

> The right treatment starts with the right diagnosis. The biggest mistake patients make is treating all hair loss the same way. A medication that helps pattern hair loss may do very little for alopecia areata, and a patient with telogen effluvium may need trigger correction more than a strong hair-loss drug. The earlier the diagnosis is clarified, the better the chance of protecting long-term follicle health.