FREE SAMPLE · FOR MEN WITH ANDROGENETIC ALOPECIA

HOW TO REGROW YOUR HAIR

STEP BY STEP

(WITHOUT FALLING FOR SNAKE OIL)

A practical, science-based guide

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Remember: don't self-medicate. Finasteride, dutasteride, and oral minoxidil are prescription medications. Everything you read here is information to help you walk into your appointment knowing what to talk about, not a personal regimen. Don't start, change, or stop a treatment on your own, and be wary of websites or sellers offering these drugs without a prescription, because you don't know what's in them or how they've been stored. If you're already in treatment and notice anything unusual, talk to your doctor before making any decision.

This book is for informational and educational purposes only. It does not replace professional medical advice, diagnosis, or treatment.

The author is not responsible for any damage or consequence resulting from the application of the information contained in this work.

Some of the treatments mentioned in this book are not approved in the United States or the European Union for androgenetic alopecia. For more information, consult the official prescribing information.

The author declares no commercial ties or conflicts of interest with the companies, brands, or products mentioned in this work.

> *“Your truth? No, the Truth,*
> *and come with me to find it.*
> *Yours, keep it to yourself.”*
>
> ANTONIO MACHADO

How This Guide Works

This guide is written so that any man with androgenetic alopecia can understand what the science says about how to stop hair loss from progressing and regrow some of the hair he's lost, without throwing money away on treatments and products that are completely useless.

This book contains 141 scientific references. You can click the number of any reference and it will take you straight to the cited study, so you can check the information for yourself.

What Is Androgenetic Alopecia and Why Are You Losing Your Hair?

Androgenetic alopecia (AGA) is the most common cause of hair loss in men. To give you an idea: between 30% and 50% of men have it by age 50, and in the US alone we're talking about some 50 million men (1, 2, 3). So you're not the odd one out; you're in very good company.

The Two Keys: DHT and the Sensitivity of Your Follicles

AGA depends mainly on two factors: the amount of dihydrotestosterone (DHT) in your scalp, and how sensitive your follicles are to DHT. If you had no DHT, or if your follicles weren't sensitive to it, you wouldn't have AGA. It's as simple as that.

In case you're wondering, DHT is produced from testosterone by an enzyme called 5-alpha-reductase (5AR). There are several types, but the one that matters most to us is type 2, which is the most active in the scalp (4, 5, 6, 7).

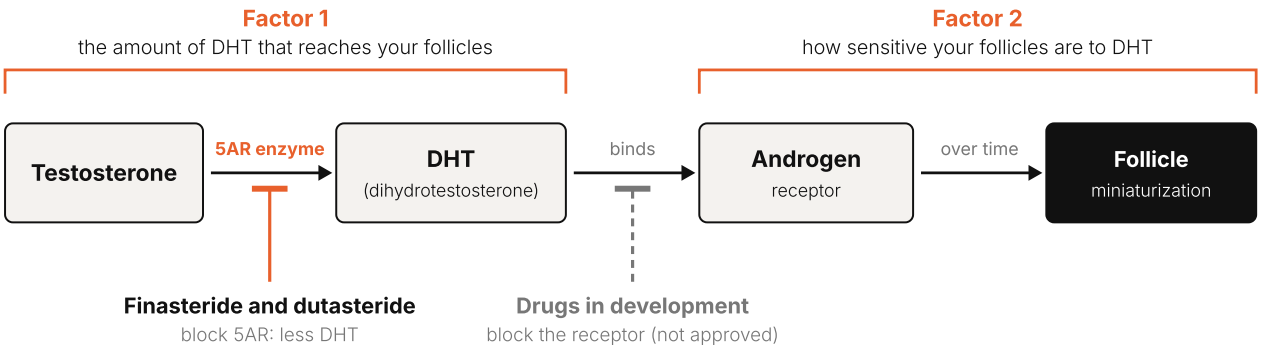


Figure 2. The two factors behind AGA and where the drugs act. Minoxidil isn't shown because it doesn't act on this pathway.

Miniaturization: What Really Happens to Your Hair

Hair has a life cycle: it grows (anagen phase), gets ready to fall out (catagen phase), and rests until it sheds (telogen phase). In follicles that are sensitive to DHT, the growth phase gets shorter cycle after cycle. The result? Each new hair comes in finer, shorter, and weaker than the last, until it practically disappears to the naked eye (though you can still see it with a digital trichoscope). This process is called **miniaturization**, and it's the real reason your hair "falls out" in AGA.

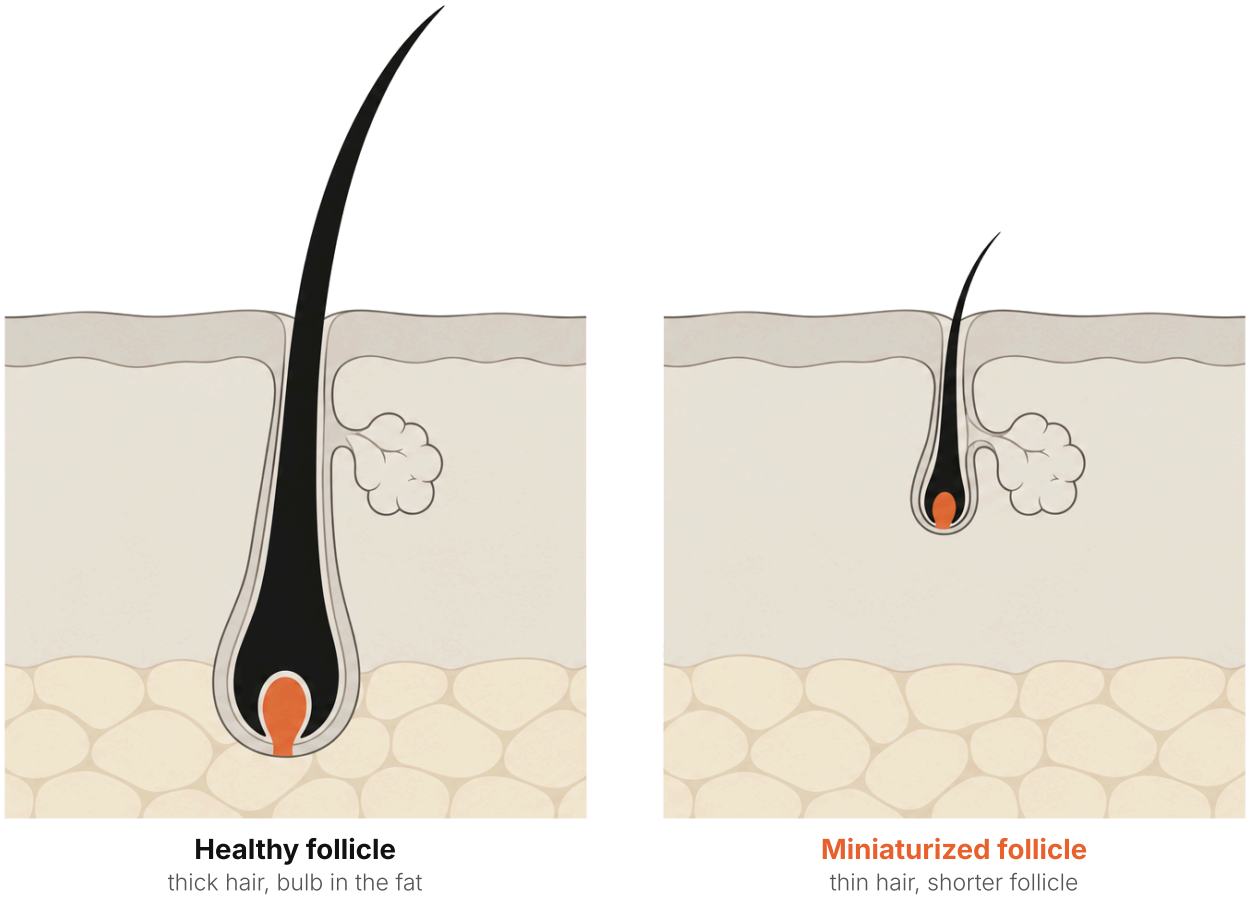


Figure 3. Healthy follicle and miniaturized follicle (illustrative diagram). In AGA, the follicle shrinks cycle after cycle and produces an increasingly thin, short hair.

A quick way to tell whether an area is miniaturized: ask yourself whether you used to have dense, healthy hair there. If the answer is yes, that hair has gone through miniaturization.

And here's what matters: the more advanced the miniaturization, the lower the chance of recovering that hair. That's why **the sooner you start treatment, the better**.

How Do You Fight It?

There are two possible approaches: reduce the amount of DHT that reaches your follicles, or reduce your follicles' sensitivity to DHT. The most effective drugs we have today take the first route. They are finasteride (1 mg), which blocks the type 2 5AR enzyme, and dutasteride (0.5 mg), which blocks both type 1 and type 2 (6). The most promising drugs currently being studied take the second route, but we'll get to those in the chapter What's Coming.

One important detail: of the two, only 1 mg finasteride is approved by the US Food and Drug Administration (FDA) to treat AGA. Dutasteride (0.5 mg) is approved for AGA only in South Korea, Japan, and Taiwan, and while long-term data (up to 5 years) exist, they come mostly from studies in Korean men, so there's still less evidence than for finasteride (8, 9).

What Stage Are You In? The Norwood-Hamilton Scale

Before you start treatment, it helps to know where you stand, because what you can expect depends on it. Most doctors and studies classify male AGA with the **Norwood-Hamilton scale**, devised by Hamilton in 1951 and expanded by Norwood in 1975, which divides it into seven stages (10, 11):

Stage	What You See
I	Minimal, almost unnoticeable recession in the frontal area
II	Receding corners appear at the temples. This is the first visible sign in most men
III	The loss spreads, especially toward the crown. This is usually considered the point where people start calling it balding
IV	More loss on the crown and the frontal area, separated by a band of hair
V	The two areas start to merge, leaving a thin, horseshoe-shaped band
VI	The bald areas merge and spread even further
VII	Almost the entire scalp is bald, except for a narrow strip around the ears and the nape

In the intermediate stages (III to V), there are also variants, depending on whether the loss is concentrated only in the frontal area (variant A) or also affects the crown (vertex variant).

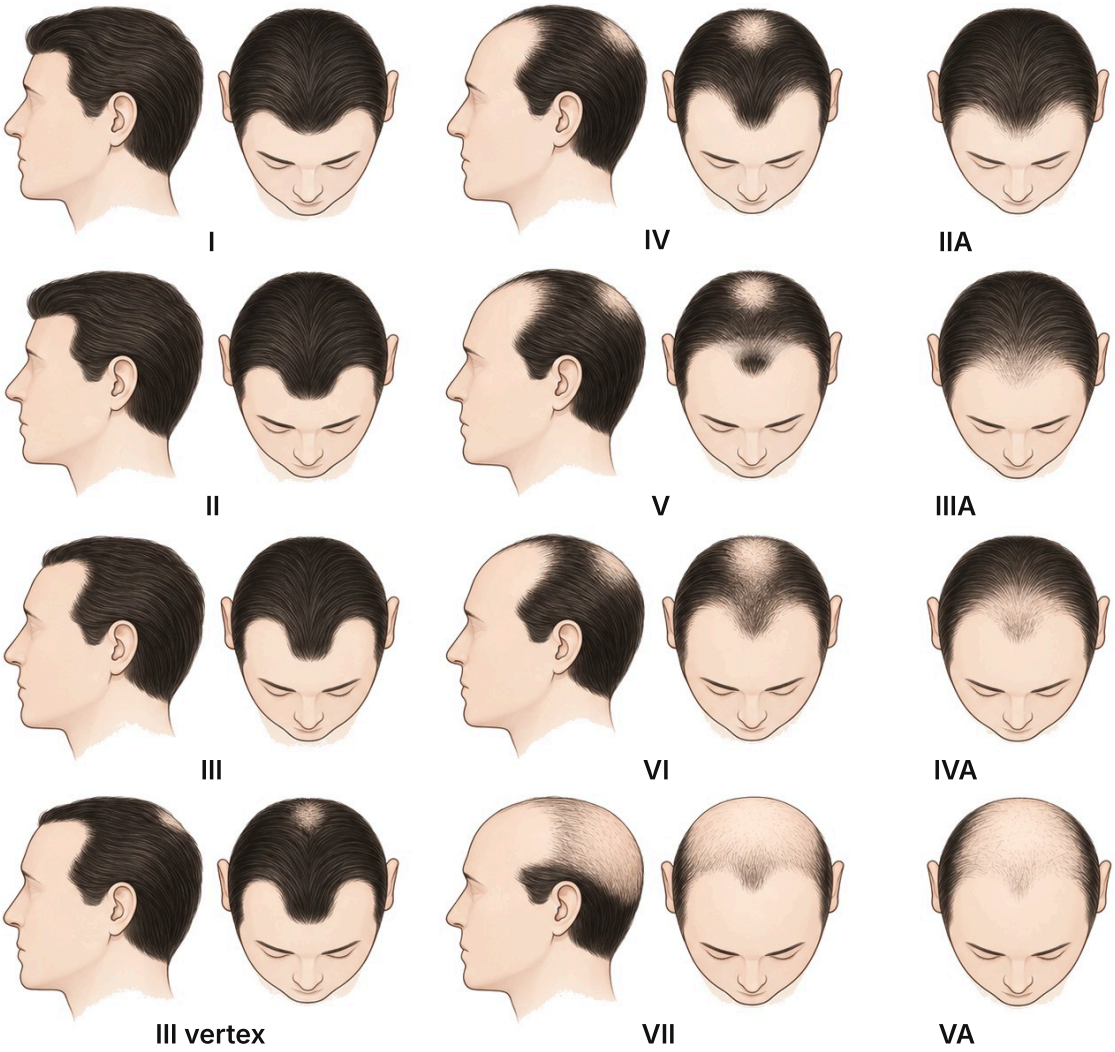


Figure 4. The Norwood-Hamilton scale.

What to Expect Based on Your Stage

- **The sooner you start, the better.** You've already seen why with miniaturization. What's still unclear is whether more advanced cases respond better or worse to treatment: some studies suggest they might improve more, but there's no consensus.
- **The more advanced your hair loss, the harder it is to get back to an ideal state,** even if the treatment works for you. As a guideline: if you start at stage V, it's reasonable to aim to improve to stage IV or even stage III; if your goal is to reach Norwood II or better, you'll most likely need a hair transplant.
- **The most affected areas respond the worst,** because reversing very advanced miniaturization is hard.
- **If you're considering a transplant,** in stages VI and VII the follicles available in the donor area can be a limiting factor.

- **Take photos today.** Changes take months to show up, and it's very easy to fool yourself. One photo a month, with the same lighting, the same angles, and the same hairstyle (front, temples, and crown), will tell you whether you're improving far better than looking in the mirror every day.

WHAT YOU NEED TO KNOW

- AGA is the most common cause of hair loss in men.
- DHT, which is formed from testosterone by the 5AR enzyme, is the main driver of AGA.
- In follicular miniaturization, each growth cycle produces a finer, shorter hair. The more advanced the miniaturization, the lower the chance of recovery.
- Finasteride and dutasteride reduce DHT. However, of the two, 1 mg finasteride is the only one approved by the FDA to treat AGA.
- The Norwood-Hamilton scale classifies male AGA into seven stages. Knowing which one you're in helps you set realistic expectations, and regular photos will tell you whether the treatment is working.

Want to dive deeper? If you want to know in depth how these drugs work and what the evidence says, I have a book dedicated exclusively to this topic: *The Truth About Finasteride and Dutasteride*.

IN THE FULL BOOK

Phase 1A Finasteride

Phase 1B [illegible]

And the rest of the path, all the way to Phase 8.

More than 130 studies cited, with a direct link to each one.

Are You Sure It's AGA?

Not all hair loss is androgenetic alopecia. Before starting any treatment, a dermatologist should confirm that what you have is AGA, because other causes of alopecia are managed very differently. Here are some of the most common:

- **Telogen effluvium.** A sudden, diffuse shedding that usually appears a few months after a trigger (surgery, childbirth, illness, certain medications, nutritional deficiencies...). It normally resolves on its own once the cause goes away (12, 13).
- **Alopecia areata.** Well-defined patches of hair loss of autoimmune origin. The follicle is preserved, and the hair can grow back (13, 14).
- **Tinea capitis.** A fungal infection, more common in children, usually showing up with scaling or pustules and requiring oral antifungal treatment (13).
- **Cicatricial (scarring) alopecias.** Uncommon. They destroy the follicle and the loss is permanent, so a dermatologist should evaluate them (13).

AGA, on the other hand, is gradual and follows a pattern (receding temples and crown). If your hair loss is sudden, shows up in patches, or comes with scaling or pustules on the scalp, see a dermatologist before starting any treatment.

> **WHAT YOU NEED TO KNOW**
>
> - Before starting any treatment, a dermatologist should confirm that what you have is AGA.
> - AGA is gradual and follows a pattern: temples and crown.
> - Sudden hair loss, hair loss in patches, or hair loss with scaling or pustules doesn't fit AGA: see a dermatologist before treating yourself.

PHASE

1A

Finasteride

We start with the drug that gives you the best odds of stopping hair loss: finasteride. If you had to pick just one treatment out of everything we'll cover in this book, the evidence points to finasteride. The reason is simple: of the two classic approved drugs (finasteride and minoxidil), it's the only one that attacks one of the root causes of AGA, the amount of DHT reaching your follicles.

You're probably wondering: if dutasteride is more potent, why not start with it right away? The evidence suggests that's not the wisest move, and I'll explain why in Phase 5A. To give you a preview: when efficacy looks similar on paper and the safety questions aren't fully resolved, the best-supported approach is to start with the most-studied drug and keep the other as a next option.

Does It Really Work?

Yes, and the data are pretty clear.

CONTINUED IN THE FULL BOOK · PHASE 1A AND PHASE 1B

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THAT'S THE END OF THE SAMPLE

The full book continues step by step: what the evidence says about each treatment, the order to try them in, and which ones you can rule out.

More than 130 studies cited, with a link to each one.

SCAN TO SEE THE FULL BOOK

FUTUREVEGAN.ORG/HOW-TO-REGROW-YOUR-HAIR