

Hair Loss in Women: Causes, Diagnosis, Management

Susan Mayne, DNP, FNP-C, DCNP
University Hospitals of Cleveland, Department of Dermatology
susan.mayne@uhhospitals.org



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Opening Case

42-year-old female, 6 months postpartum

Diffuse shedding, no scalp symptoms

Where do you start?



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Why This Matters

Hair loss affects self-esteem
and mental health

WHNPs are often first point
of contact

Early recognition enables
timely dermatology referral



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The Key Clinical Question

Is this scarring or non-
scarring alopecia?

Scarring = permanent loss,
refer immediately

Non-scarring = potentially
reversible



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Case 2 – Scarring Red Flags

38-year-old black female,
smooth patches at crown

Burning, pain, mild scalp
discoloration

Refer to dermatology, but
why?



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Scarring Conditions

Central Centrifugal
Cicatricial Alopecia (CCCA)

Lichen planopilaris

Discoid lupus

Traction alopecia



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Non- Scarring Sorting by Pattern

Focal patches
alopecia areata

Diffuse shedding
telogen effluvium

Patterned thinning
female pattern hair loss



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Alopecia Areata

Autoimmune, round smooth
patches

Often spontaneous
regrowth within 1 year

Mild cases: watchful waiting
is reasonable

Positive hair pull test =
active disease



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Telogen Effluvium

Diffuse shedding weeks after
a trigger

Triggers: illness, childbirth,
meds, stress, low iron/vit D

Labs: CBC, CMP, iron studies,
TSH

Self-limited once trigger
resolves

Case 3

47-year-old female,
frontal/vertex thinning,
gradual onset

No inflammation or scale

Common condition with
treatment options that can
be started immediately

Female Pattern Hair Loss (FPHL)

Most common non-scarring
cause in women

Genetic + hormonal
(androgen)

Frontal/vertex thinning,
follicle miniaturization

DHT drives progression in
susceptible patients

FPHL Treatment Algorithm

Confirm diagnosis– exclude
scarring, hyperandrogenism

Start topical minoxidil, can
add oral antiandrogen

Reassess response after 6-12
months of therapy

Can escalate treatment –
add oral minoxidil, PRP, LLLT

Hair transplant or wigs if
refractory

Other Treatment Options

Oral low-dose minoxidil is alternative if poor response

Platelet-rich plasma (PRP) – costly, limited standardization

Low-level laser therapy is comparable to minoxidil

Hair transplant-refractory cases



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Oral Antiandrogen Options

Spironolactone 100-200 mg/day; monitor potassium

Finasteride 1.5-2.0 mg/day

Dutasteride 0.5 mg/day for postmenopausal women only

All contraindicated or cautioned in pregnancy



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Quick Reference Labs & Dosing

Diffuse shedding: CBC, CMP, iron studies, vit D, TSH

Spirolonolactone: start 50 mg, titrate to 100-200 mg/day

Minoxidil 1.25 mg/day

Finasteride: 2.5-5 mg/day

Dutasteride 0.5 mg/day, postmenopausal only



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A Word on Supplements

Nutraceuticals are widely marketed, not FDA-approved

No evidence supports biotin for hair loss

Unclear efficacy for other supplements



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Take-Home Points

Distinguish scarring vs non-scarring first

Refer promptly if you suspect scarring alopecia

FPHL: topical minoxidil + antiandrogen is first-line

Set expectations, this is a marathon not a sprint



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Discussion Question

Patient-perceived improvement often lags clinical exam

How do you handle “it’s not working” at month 3?

Barriers to timely derm referral in your setting?



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