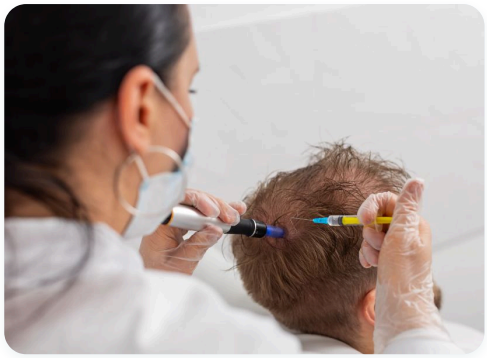
HAIR RESTORATION

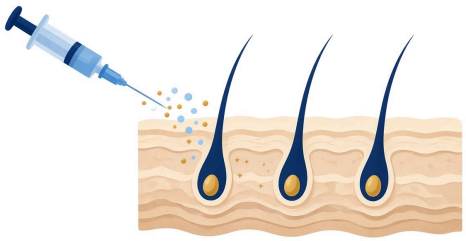
PRP, Exosomes and Stem Cells for Hair

What each treatment is, what the evidence supports, and when they are worth adding to a transplant – or using instead of one



All three aim to do the same thing: wake up follicles that are miniaturising but not yet gone, and support the growth of hair that is already there. None of them creates follicles where none remain.

WHERE REGENERATIVE TREATMENTS CAN ACT



A miniaturising follicle can be supported; a follicle that has closed cannot be revived. This is the line every treatment on these pages has to respect.

AT A GLANCE

YOUR OWN BLOOD

PRP

Platelet-rich plasma, separated from a small blood sample and injected into the scalp. The best studied of the three.

CELL SIGNALS

Exosomes

Tiny vesicles carrying growth signals, applied to the scalp. Promising early data; less long-term evidence.

REGENERATIVE

Stem-cell therapy

Usually a concentrate from your own fat or scalp tissue. Still largely investigational for hair.

The honest ceiling

At their best these treatments slow loss, thicken existing hair and improve the survival of transplanted grafts. They do not restore a hairline that has receded, and they do not replace a transplant where follicles are gone.

Ask which, if any, of these is relevant to your pattern of loss.

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How each one works

The names sound similar; the procedures and the evidence are not. Here is what actually happens with each, and what the studies support.

PRP, STEP BY STEP

1. **Draw**
   A small blood sample, as for a routine test.
2. **Spin**
   A centrifuge separates the platelet-rich layer.
3. **Inject**
   Fine injections across the thinning area.
4. **Repeat**
   Usually three to four sessions, then maintenance.

WHAT THE EVIDENCE CURRENTLY SUPPORTS

	EVIDENCE	WHAT IT TENDS TO ACHIEVE	HONEST CAVEAT
PRP	Several controlled trials	Increased density and hair calibre in early loss	Protocols vary; results fade without maintenance
Exosomes	Early studies, small numbers	Signals that support follicle activity	Products are not standardised; long-term data is thin
Stem-cell	Mostly case series	Possible support of existing follicles	Largely investigational for hair; claims outrun data

A fair summary as of this guide's date. Evidence moves; ask what is current.

WHY PROTOCOLS MATTER AS MUCH AS THE NAME

- ✓ **Concentration.** PRP that is not concentrated enough does little; the preparation method is the treatment.
- ✓ **Depth and spacing.** Injections have to reach the follicle level and cover the area evenly.
- ✓ **Course and maintenance.** A single session is a trial, not a treatment.

Ask how a clinic prepares its PRP — the answer tells you a lot.

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Who benefits, and who does not

The same treatment is excellent for one patient and pointless for another. The difference is almost always how much living follicle there is left to support.

TENDS TO BENEFIT

- ✓ Early, diffuse thinning with hair still present
- ✓ Miniaturised hair that has not yet disappeared
- ✓ Patients who want to slow loss while deciding on surgery
- ✓ Transplant patients, to support healing and graft survival

UNLIKELY TO BENEFIT

- ✗ Smooth, shiny areas with no visible hair at all
- ✗ Long-established recession at the hairline
- ✗ Scarring hair loss, which needs a diagnosis first
- ✗ Anyone expecting a transplant-sized result

THREE PATIENTS, THREE ROLES FOR TREATMENT

EARLY

Thinning at 28, no bald areas

Hair everywhere, just finer than it was.

→ **PRP course plus medical treatment; reassess in a year**

AROUND SURGERY

Transplant booked

Wants the grafts to take well and the native hair to hold.

→ **PRP or exosomes alongside the transplant**

ADVANCED

Shiny crown, receded front

Little living follicle in the areas that matter.

→ **Transplant is the discussion; injections are secondary**

ⓘ A clinic that recommends a course of injections for a smooth, hairless area is treating your hope, not your scalp. Ask what they expect the treatment to act on.

Send a photograph and ask whether there is enough living follicle to support.

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Around a transplant, and what a course looks like

The most consistent use of these treatments is not instead of a transplant but alongside one – supporting healing, graft survival and the native hair that frames the result.

A TYPICAL COMBINED PLAN

BEFORE

Assessment

Decide whether injections are relevant at all.

SURGERY DAY

First session

Often given during or just after the transplant.

MONTH 1–3

Course

Monthly sessions through the quiet phase.

MONTH 6+

Maintenance

Two to three sessions a year if it is helping.

HOW TO JUDGE WHETHER IT IS WORKING

Photographs

Same angles and light, every month.

Give it six months

Hair cycles are slow; judging at eight weeks judges nothing.

Shedding first

Less hair on the pillow is often the first sign.

Then calibre

Hairs get thicker before they get more numerous.

ASKED ALMOST EVERY TIME

Does it hurt?

Fine needles and, where needed, local anaesthetic. Most people describe it as uncomfortable rather than painful.

Can I combine it with medication?

Usually yes, and the combination often does better than either alone. Your doctor decides.

Is it a one-off?

No. Benefit depends on a course and on maintenance; stopping means the effect fades over months.

YOUR NEXT STEP

Talk to us before you decide anything

Free Consultation
A conversation with a coordinator, with no commitment.

Send Your Photos
Our medical team reviews them and replies with an assessment.

WhatsApp Us
Questions answered in your own language, usually the same day.

✓ Free consultation · Free medical evaluation

WHATSAPP US

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WHY ESTECENTER?

- ✓ Experienced medical teams
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This guide is for informational purposes.
Treatment suitability is determined after medical evaluation.