

Anatomic Points and Labels for Trichoscopic Scalp Imaging: A Narrative Review and Proposed Framework

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Abstract: Trichoscopy is an established component of the hair loss consultation, yet two related documentation gaps persist: there is no widely accepted set of standardized anatomic points for trichoscopic image capture on the scalp, and no widely adopted shorthand for labeling captured images within the electronic medical record (EMR). In our experience, free-text descriptions vary between clinicians and between visits, limiting longitudinal comparison. This narrative review summarizes existing anatomic terminology and sampling frameworks relevant to clinical trichoscopy, identifies the practical gap, and presents a region-anchored framework that pairs a set of specific scalp imaging points with a corresponding alphanumeric shorthand for direct EMR entry. The framework combines bone-anchored zonal terminology with a single-letter regional prefix, a numerical suffix, and an “L” (left) or “R” (right) designation, producing concise labels of two to five characters. These labels accommodate the variable imaging needs of common alopecias and are intended to complement, not replace, existing sampling protocols. The framework has been used to document approximately 150 patients with hair loss in a single tertiary referral hair clinic since 2025 but has not been formally validated for inter-observer reproducibility; a multi-centre validation study would be a useful next step.

Keywords: trichoscopy; dermoscopy; hair loss; alopecia; scalp anatomy; medical recordkeeping; scalp mapping

1. Introduction

Trichoscopy is an established component of the hair loss consultation, and capturing dermoscopic images at patient visits is helpful in longitudinal evaluation [1,2]. Two related documentation gaps persist. First, there is no widely accepted set of standardized anatomic points for trichoscopic image capture on the scalp; Jayasree et al. noted the absence of standard anatomic points for scalp trichoscopy in 2021 [3], and a 2025 conference abstract reporting a systematic review of trichoscopic diagnostic accuracy has continued to identify image standardization as a research priority [4]. To our knowledge, this gap has not been substantively addressed in the interim. Second, even when sites are sampled, the absence of a standardized shorthand means free-text EMR entries vary between users and between visits. Without standardized points, two clinicians may sample different regions of the same patient on successive visits; without standardized labels, even consistent sampling cannot be retrieved or compared efficiently in the EMR. Both elements are needed for reproducible longitudinal documentation.

This review focuses on defining anatomic imaging points and labels for scalp trichoscopy. The question of which subset of points to image for a particular alopecia is a sampling protocol question, partially addressed by Jayasree et al. [3], and is outside the scope of this proposal. The clinical examples in Section 4.4 are intended to illustrate how the labels are used in our tertiary referral hair clinic, not to prescribe a sampling protocol.



The review summarizes existing anatomic terminology and sampling frameworks relevant to clinical trichoscopy, outlines anatomic landmarks of practical use at the bedside, and presents a region-anchored framework comprising a set of specific scalp imaging points and a corresponding alphanumeric shorthand for EMR entry or other documentation contexts.

Relevant literature was identified through targeted PubMed searches using terms including scalp anatomy, trichoscopy, dermoscopy, scalp imaging, scalp mapping, and hair loss documentation, supplemented by reference list review of identified articles. As a narrative review, no formal systematic search protocol was applied.

2. Existing Frameworks for Scalp Anatomic Terminology and Sampling

Several frameworks address adjacent problems, but none was designed for routine EMR-compatible labeling of trichoscopic image sites. The most directly relevant prior work spans hair restoration surgery, dermatopathology, trichoscopy, neurology, and general surface anatomy nomenclature.

2.1. Beehner: Nomenclature for Hair Restoration Surgery

Beehner proposed a nomenclature for the balding scalp focused on hair transplant planning, dividing the scalp into three major zones (frontal, midscalp, vertex) and defining the vertex transition point (VTP) as the palpable midline landmark where the scalp begins to slope from horizontal to vertical, marking the anterior boundary of the vertex [5]. The framework was designed around the requirements of restoration surgery rather than diffuse imaging and does not address the temporal or occipital scalp in detail. It does not provide granular point labels suitable for serial trichoscopic image capture.

2.2. Wohltmann and Sperling: Zone-Based Biopsy Site Selection

Wohltmann and Sperling described a six-zone scheme (frontal, temporal, parietal, crown, vertex, occipital) used to organize differential diagnoses by biopsy site, illustrating that specific scalp regions are prone to particular alopecias [6]. The scheme is widely used in dermatopathology and provides useful regional descriptors, but it was not designed to support serial imaging documentation and does not propose a shorthand for individual sampling points within a region.

2.3. Jayasree et al.: Five-Point Trichoscopy

Jayasree et al. proposed five fixed reference points (frontal, bilateral temporal, vertex, occipital) anchored to the glabella and the external occipital protuberance for trichoscopic assessment and follow-up [3]. The protocol is practical for whole-scalp surveillance and provides a useful baseline minimum, but five points are insufficient for the dense regional sampling required in certain hair loss conditions where multiple hairline and patchy involvement points must be tracked over time.

2.4. Beltrami et al.: Updated Consensus Surface Anatomy

Beltrami et al. recently reviewed updated consensus surface anatomy terminology and endorsed the use of frontal, parietal, temporal, occipital, and vertex for the scalp, explicitly preferring these bone-anchored terms over “anterior”, “posterior”, and “mid” scalp [7]. Their work establishes recommended terminology but does not propose a detailed map of specific scalp areas or a labeling shorthand for clinical use.

2.5. Kasprzak et al.: The Follicular Map

Kasprzak et al. described the Follicular Map (FMap), which uses graphical pattern recognition of follicular orifices in trichoscopic images to re-identify the same scalp location across visits [8]. The FMap addresses longitudinal site re-identification at the level of individual follicles, requires dedicated software for pattern matching, and is complementary to the regional anatomic labeling approach proposed here.

2.6. EEG Electrode Placement Nomenclature (the 10-10 System)

Outside dermatology, the most highly developed standardized scalp positioning system is the International Federation of Clinical Neurophysiology (IFCN) 10-10 system, derived from the Jasper 10-20 system and elaborated through the modified combinatorial nomenclature [9]. Electrode positions are placed using percentage-based measurements between bony landmarks (nasion, inion, and the left and right preauricular points), with names combining letters indicating an approximate underlying lobe (F, T, P, O; C for central) with numbers (odd on the

left, even on the right, z for midline). The system was designed to capture cortical electrical activity and does not reference hairlines or hair-distribution features. Several of its midline positions coincide approximately with bone-anchored landmarks shared by the framework proposed here; these correspondences are discussed in Section 5.

2.7. Synthesis

Together, these frameworks provide zonal terminology, identify important landmarks, and describe sampling protocols at differing levels of granularity. None, however, both defines a set of specific scalp imaging points sufficient for the variable capture required across different alopecias and pairs those points with a labeling shorthand suitable for direct EMR entry. The 10-10 EEG system [9] addresses both elements but for a different clinical purpose and without reference to hair-bearing landmarks; the FMap [8] addresses longitudinal site re-identification but at the follicular level and only with software. A practical framework for clinical trichoscopy would need to define specific anatomic sampling points grounded in current consensus terminology and pair them with short, EMR-compatible labels, scalable to the level of detail required by a given disease.

3. Anatomic Landmarks Relevant to Trichoscopy

Scalp regions are surface anatomy constructs defined by external landmarks with approximate osseous correlates rather than strict bony boundaries. Clinically useful landmarks include the superior temporal line, coronal suture, inion, ear position, and scalp contour transitions. Inter-individual variation in skull shape and scalp contour means these regional boundaries should be treated as proportional approximations rather than fixed measurements.

The superior temporal line is a curved osseous ridge marking the superior boundary of the temporal fossa and serves as a clinically useful landmark separating the temporal and parietal scalp regions [10–12]. Surface anatomically, it may be approximated as a palpable curved ridge beginning above the lateral eyebrow and lateral orbital rim and coursing posterosuperiorly across the lateral scalp. It represents the posterosuperior continuation of the temporal line of the frontal bone [12] and provides attachment for the temporal fascia [10,13]. The coronal suture serves as an approximate surface landmark separating the frontal scalp from the midscalp. In clinical practice, it is frequently estimated using surface approximations such as a point approximately two fingerbreadths anterior to the ear; however, the position of the coronal suture is known to be variable [14,15]. The VTP refers to the point in the posterior midscalp where the scalp contour transitions from a horizontal to a downward-sloping plane, marking the anterior boundary of the vertex scalp [5]. The inion, defined as the most prominent point of the external occipital protuberance, is identified by palpating the posterior midline of the occiput and locating the bony projection at the convergence of the superior nuchal lines, which extend laterally toward the mastoid process [16].

4. A Proposed System of Scalp Imaging Points and Labels

The labels below define a complete set of anatomic reference points that function as a map, from which the clinician selects the points relevant to a given patient; it is not intended that all points be captured at any single encounter. The specific positions and their spacing are pragmatic clinical conventions developed in a single tertiary referral hair clinic rather than evidence-derived or formally validated locations, and are offered as a practical starting point for discussion and future refinement.

4.1. Zonal Terminology Adapted from Prior Frameworks

The proposed system uses bone-anchored zonal terminology (frontal, temporal, parietal, occipital, vertex) broadly consistent with Beltrami et al. [7], adapted for hair-loss practice in three ways. First, Beehner’s “midscalp” [5] is retained as a distinct central zone between the frontal scalp and the vertex; this area corresponds to what Beltrami et al. include within “parietal.” This represents an adaptation rather than identical use of Beehner’s term: he applied “midscalp” within a three-zone balding scheme (frontal, midscalp, vertex) [5], whereas here it is one of six regions in a more granular anatomic scheme. Second, “parietal” is restricted to the lateral upper scalp above the superior temporal line, connecting the frontal, midscalp, vertex, and occipital regions along the lateral convexity of the skull. Third, the vertex is treated as a distinct top-level region rather than as a subregion within the parietal-occipital distribution, reflecting its clinical importance in male pattern hair loss, lichen planopilaris, folliculitis decalvans, and similar conditions that selectively target this area.

4.2. Label Construction

Each anatomical zone is assigned a single-letter prefix: frontal (F), temporal (T), midscalp (M), parietal (P), vertex (V), and occipital (O). Within the midline zones, numerical suffixes (1, 2, 3) increase from anterior to

posterior. Lateral positions are designated “L” (left) or “R” (right) relative to the midline. Hairline points incorporate an “H” (hairline) within the abbreviation (FH, TH, OH) and are numbered anterior to posterior when more than one point is recorded.

The frontal region uses two fixed anterior reference points. F0 marks the estimated original mid-frontal hairline. In patients without frontal hairline recession, F0 coincides with FH; in patients with recession, the original hairline is estimated clinically at the topmost (most superior) forehead wrinkle produced by the frontalis muscle, which approximates the junction of the frontalis muscle and the galea aponeurotica [17], supported by the converging cues of skin weathering and the pseudo-fringe sign validated for original-hairline identification in frontal fibrosing alopecia (FFA) [18]. F1 is positioned just posterior to F0 (approximately 2 to 3 cm), such that the dermatoscope field captures hair-bearing scalp without including forehead skin in patients without frontal hairline recession. Anchoring F1 to F0 rather than to the current hairline keeps both frontal reference points fixed to scalp position across visits, so that serial images document change at a stable location even as the hairline recedes. Together with M1, M2, V1, and the occipital points, F0 and F1 constitute the fixed-anchor set of the framework, defined by bone or stable surface landmarks; the hairline points (FH and the frontal and temporal hairline series) instead track the current hairline by design and are expected to move in progressive recession. This anterior placement is intentional: early central frontal changes in female pattern hair loss, the pseudo-fringe pattern of FFA, and the posterior margin of FFA-related inflammation are most reliably detected immediately behind the hairline rather than midway between F0 and M1. The midscalp contains two fixed midline landmarks: M1, positioned at the approximate coronal suture, and M2, positioned approximately at the level of the external auditory canals, providing more even spacing between the frontal scalp, midscalp, and vertex (V1). The VTP is labeled V1; the centre of the whorl is V2. O2 is opposite the nasion when the head is in the anatomic position (the head is upright with the chin level), and O3 is at the inion (external occipital protuberance). O2 lies near the midpoint of the occipital region and corresponds approximately to the point of maximal posterior convexity of the occipital scalp, although the precise location of that convexity varies with cranial shape. O1 is positioned on the superior occipital midline approximately 2 to 4 cm inferior to V2, between V2 and O2.

Scalp regions and their boundaries are shown in Figure 1 and defined in Table 1. The full set of proposed labels is shown in Figure 2 and listed in Table 2. Each label is a short alphanumeric string of two to five characters, suitable for rapid entry into any free-text EMR field, including by two-finger typing on a smartphone, which reflects how trichoscopic documentation is often performed at the point of care. The labeling convention is summarized in Box 1.

Box 1. Reading the labels at a glance.

The entire system follows four rules:

1. Letter = region: F (frontal), M (midscalp), P (parietal), T (temporal), V (vertex), O (occipital).
2. Number = position front to back within a region (1 is most anterior).
3. L or R = left or right of the midline; no letter means midline.
4. H = a hairline point (for example FH, TH, OH).

Example: M2L is the midscalp, second point back, left of midline.

The points form a reference map; the clinician photographs and labels only the points relevant to the patient in front of them.

Table 1. Scalp surface anatomy regions referenced in the labeling system.

Scalp Region	Description and Boundaries	Clinically Useful Landmarks
Frontal scalp	Anterior scalp from the original frontal hairline (F0) posteriorly to approximately the level of the coronal suture (~2 fingerbreadths anterior to the ear). In the absence of recession, F0 coincides with the current frontal hairline.	Original frontal hairline (F0); topmost forehead wrinkle at the frontalis-galea junction; approximate coronal suture position (~2 fingerbreadths anterior to the ear)

Table 1. Cont.

Scalp Region	Description and Boundaries	Clinically Useful Landmarks
Midscalep	Central superior scalp between the frontal scalp anteriorly and the vertex posteriorly, bounded laterally by the parietal scalp.	Approximate coronal suture region (~2 fingerbreadths anterior to the ear); VTP
Vertex scalp	Posterior-superior scalp centred on the hair whorl. The vertex begins anteriorly at the VTP, where the scalp contour changes from horizontal to downward-sloping. V1 marks the anterior vertex or VTP; V2 marks the central whorl.	Hair whorl; VTP
Vertex transition point (VTP)	Palpable point in the posterior midscalep where the scalp plane transitions from horizontal to downward-sloping. Identified by running a finger posteriorly along the midline until the contour begins to descend. Approximates the lambda region but is defined by surface contour rather than cranial sutures. Marks the anterior boundary of the vertex scalp.	Posterior midscalep contour change
Parietal scalp	Superior-lateral scalp above the superior temporal line and the temporal scalp, connecting the frontal, midscalep, vertex, and occipital scalp regions along the lateral convexity of the skull.	Superior temporal line; lateral scalp convexity
Temporal scalp	Lateral scalp overlying the temporalis muscle, located anterior, superior, and slightly posterior to the ear, inferior to the superior temporal line.	Ear; superior temporal line; temporalis muscle
Occipital scalp	Posterior scalp from the vertex inferiorly to the occipital hairline.	Occipital hairline; inion (external occipital protuberance); point of maximal posterior convexity; nasion-opposite plane with head level

Table 2. Proposed labels for trichoscopic scalp imaging.

Label	Region	Anatomical Anchor
F0	Original frontal hairline	Estimated original mid-frontal hairline; coincides with FH when there is no recession; in recession, estimated at the topmost forehead wrinkle at the frontalis–galea junction, with skin weathering and the pseudo-fringe sign [17,18]
FH	Frontal hairline	Midline at the anterior frontal hairline
FHL, FHR	Frontal hairline, left and right	Off-midline at the anterior frontal hairline, left and right
FTHL, FTHR	Frontotemporal apex, left and right	Junction of frontal and temporal hairlines
F1	Frontal midline 1	Frontal midline just posterior to F0 (~2–3 cm), positioned so the dermatoscope field captures hair-bearing scalp without including the forehead in those without frontal hairline recession; fixed to scalp position across visits
THL1, THR1	Anterior temporal hairline, left and right	Most anterior temporal hairline point
THL2, THR2	Mid temporal hairline, left and right	Mid temporal hairline, just anterior to the ear; visible on lateral views
THL3, THR3	Posterior temporal hairline, left and right	Posterior to the ear (retroauricular); visible on lateral views
T1L, T1R	Temporal 1, left and right	In line with M1 and P1, just anterior to the ear
T2L, T2R	Temporal 2, left and right	In line with M2, just superior to the ear
M1	Midscalep midline 1	Anterior midscalep midline, at the coronal suture (~2 fingerbreadths anterior to the ear)
M1L, M1R	Midscalep 1, left and right	Off-midline at the M1 level
M2	Midscalep midline 2	Posterior midscalep midline, approximately at the level of the external auditory canals
M2L, M2R	Midscalep 2, left and right	Off-midline at the M2 level

Table 2. Cont.

Label	Region	Anatomical Anchor
P1L, P1R	Parietal 1, left and right	Lateral scalp above the superior temporal line, coronally in line with M1
P2L, P2R	Parietal 2, left and right	Lateral scalp above the superior temporal line, coronally in line with M2
P3L, P3R	Parietal 3, left and right	Lateral scalp above the superior temporal line, coronally in line with V1 (most posterior parietal)
V1	Vertex 1 (VTP)	Palpable midline landmark at the vertex transition point
V1L, V1R	Vertex 1, left and right	Off-midline at the V1 level
V2	Vertex 2	Centre of the hair whorl
V2L, V2R	Vertex 2, left and right	Off-midline at the V2 level
O1	Occipital 1	Superior occipital midline, approximately 2 to 4 cm inferior to V2, sitting between V2 and O2.
O1L, O1R	Occipital 1, left and right	Off-midline at the O1 level
O2	Occipital 2	Approximately 3 cm superior to the inion; in anatomic position (with the head upright and the chin level), lies opposite the nasion; corresponds approximately to the point of maximal posterior convexity of the occipital scalp
O2L, O2R	Occipital 2, left and right	Off-midline at the O2 level
O3	Occipital 3 (inion)	Midline at the inion (external occipital protuberance), a palpable landmark
O3L, O3R	Occipital 3, left and right	Off-midline at the O3 level
OH	Occipital hairline	Midline occipital hairline
OHL, OHR	Occipital hairline, left and right	Lateral occipital hairline points

Additional posterior or lateral labels may be appended as needed. VTP, vertex transition point.

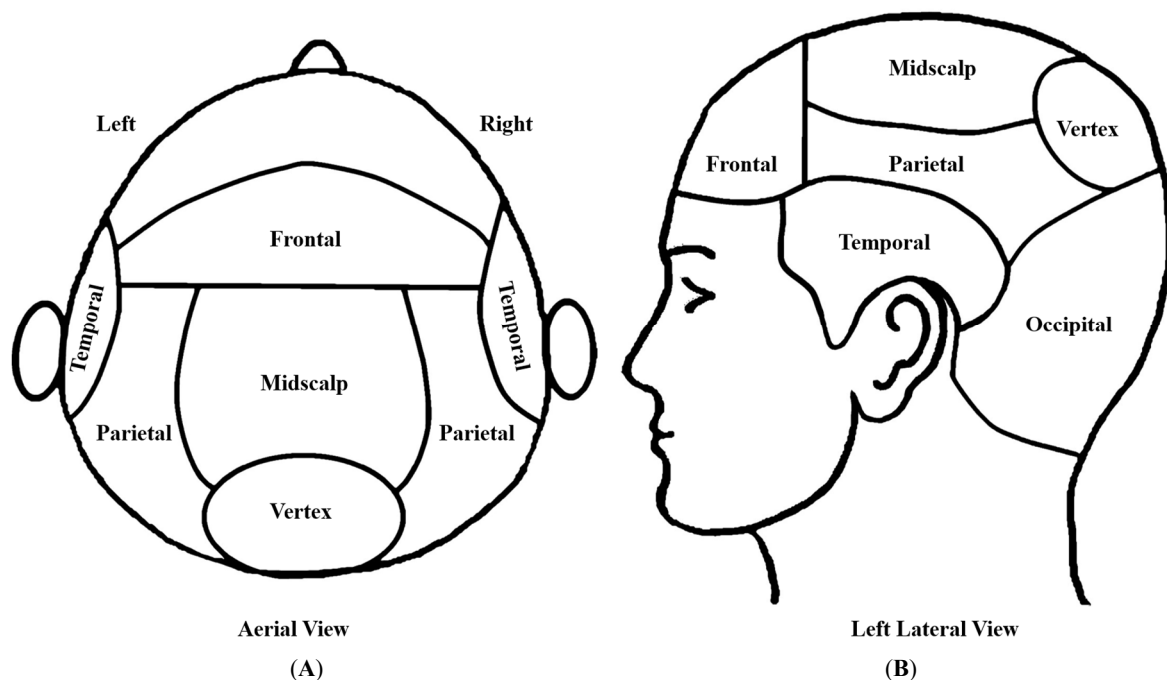


Figure 1. Anatomical zones of the scalp on aerial/superior (A) and left lateral (B) views. The zonal terminology follows bone-anchored scalp regions (frontal, parietal, temporal, occipital, vertex) consistent with Beltrami et al. [7], with three modifications for hair-loss practice: “midscalp” is retained as a distinct central zone (a term used by Beehner [5]); “parietal” is restricted to the lateral upper scalp above the superior temporal line; and the vertex is treated as a distinct top-level region. The figure is entirely original artwork created by the author and is not adapted or reproduced from any previously published image.

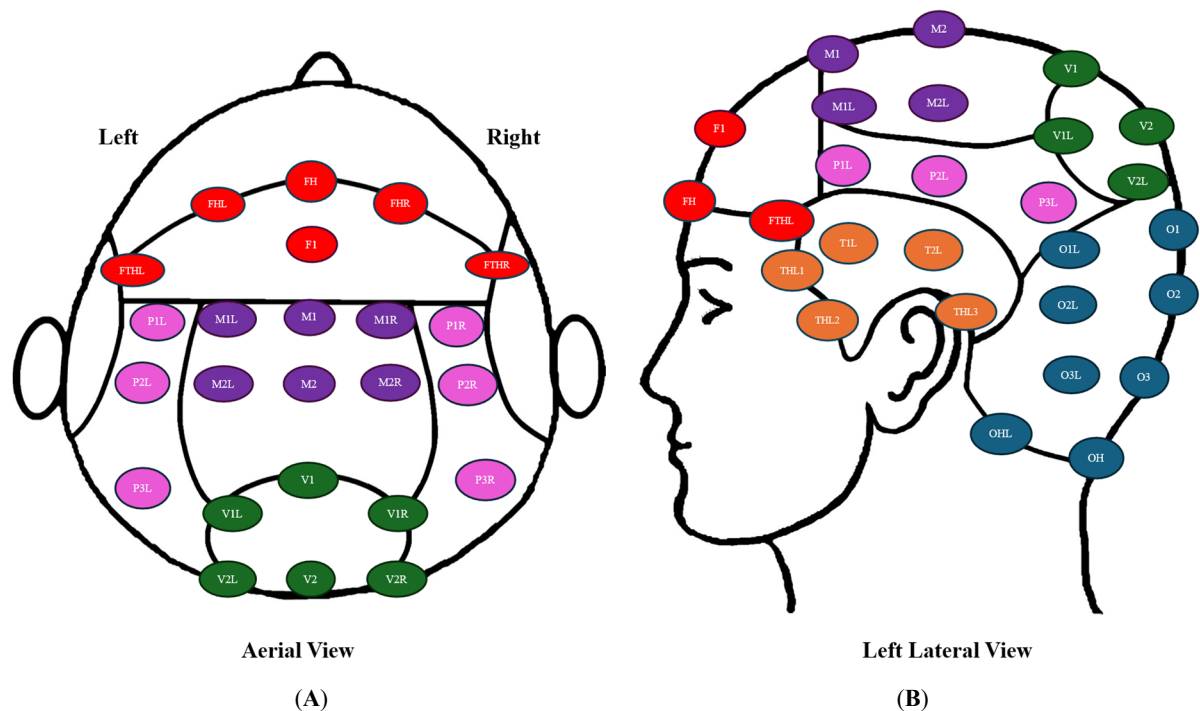


Figure 2. Proposed labeling points for trichoscopic image capture on aerial/superior (A) and left lateral (B) views. Frontal (red), temporal (orange), midscalp (purple), parietal (pink), vertex (green), and occipital (blue) regions are colour-coded. L and R denote left and right of the midline; H within an abbreviation denotes hairline. F0 marks the original frontal hairline and coincides with the FH position shown when there is no frontal hairline recession; in recession, F0 is estimated anterior to the current hairline as described in the text and Table 1. The figure is entirely original artwork created by the author and is not adapted or reproduced from any previously published image.

4.3. Regional Dimensions and Point Spacing

The frontal scalp extends from the original frontal hairline (F0) to the coronal suture, measuring approximately 4 to 5 cm in the anteroposterior dimension; the midscalp spans approximately 7 to 9 cm, the vertex region approximately 5 to 7 cm, and the occipital scalp approximately 12 to 15 cm, depending on the position of the VTP and occipital hairline. These figures are intended as proportional guides rather than fixed anthropometric measurements; the labels scale to individual scalp size. The framework deliberately uses visible or palpable surface landmarks rather than craniometric points defined by cranial sutures, because the sutures are neither visible nor reliably palpable in adults and therefore cannot guide point placement at the bedside. Where a suture is referenced (for example, the coronal suture at M1), it serves as an anatomical referent, and the point is located clinically by surface approximation rather than by palpating the suture itself. Midline spacing between adjacent labeled points is approximately 2 to 4 cm in most regions, sufficient for near-complete coverage with minimal overlap when using a dermatoscope with a 32 mm field diameter (DermLite DL5). Additional posterior or lateral sampling points can be added without disrupting the overall mapping framework (for example, an M3 between M2 and V1 in patients with a longer midscalp); conversely, in patients with smaller scalp dimensions, adjacent labels in a region (for example, P2 and P3) may sit close enough together that imaging both is redundant, and only the more clinically relevant point need be captured.

4.4. Application to Common Alopecias

The labels accommodate the variable imaging needs of different alopecias. The examples below describe the points typically captured in our tertiary hair clinic and are intended to illustrate how the labels are used in practice rather than to prescribe a protocol. For FFA, we may capture the full frontal hairline (FH, FHL, FHR, FTHL, FTHR) and adjacent temporal hairline points (THL1, THL2, THL3, THR1, THR2, THR3), and occasionally occipital hairlines (OH, OHL, OHR). For LPP, we image the midline (F1, M1, M2, V1, V2) and add off-midline midscalp points (M1L/R, M2L/R) based on clinical involvement. For male pattern hair loss (androgenetic alopecia, AGA), we capture the frontotemporal apices (FTHL, FTHR) and the vertex (V1, V2), with an occipital reference (O1 or O2) for comparison. For female pattern hair loss, we capture the frontal midline (FH, F1) and midscalp midline (M1, M2), again with an occipital reference; relative occipital sparing in pattern hair loss makes occipital

comparison useful in both sexes [6]. These groupings are practical templates rather than rigid protocols; the underlying labels accommodate any combination of points required clinically, including for alopecia areata, traction alopecia, and telogen effluvium, where image selection is guided by the distribution of involvement. In addition, standard global photographs are obtained at every visit (top and occipital view [both with hair centre parted], frontal, left lateral, and right lateral).

5. Discussion and Limitations

The proposed framework addresses two related gaps in clinical trichoscopy. It defines a set of specific anatomic points sufficient for the imaging needs of common alopecias, using bone-anchored zonal terminology aligned with current consensus surface anatomy [7], with Beehner's midscalp retained as a distinct central zone [5] and the vertex treated as a separate top-level region in recognition of its clinical importance. It pairs those points with short, intuitive alphanumeric labels that can be entered into the EMR in seconds, addressing a practical barrier to consistent longitudinal documentation that prior frameworks did not target. The proposal is intended as a low-overhead solution for clinicians whose trichoscopy workflow consists of a dermatoscope and a digital camera or smartphone, where image labeling and location documentation rely entirely on free text. Commercial trichoscopy imaging platforms automate the quantitative analysis of captured images and may offer proprietary interfaces for marking image locations on a scalp diagram, and image-based methods such as the Follicular Map [8] re-identify the same scalp site at the follicular level; these are complementary rather than competing approaches to longitudinal documentation.

Several of the proposed midline labels coincide approximately with positions in the IFCN 10-10 EEG electrode system [9]. The inion serves as a shared anchor for both Iz and O3. Cz, at 50% of the nasion-inion arc and on the coronal line through the preauricular points, lies approximately at M2, which is anchored to the level of the external auditory canals. FCz, at approximately 40% of the nasion-inion arc, lies approximately at M1, which is anchored to the approximate coronal suture position. Oz, at 10% anterior to the inion, lies approximately at O2. These correspondences are approximate rather than identical, as the 10-10 system anchors all positions to percentage-based measurements between bony landmarks, whereas the proposed dermatologic framework additionally references the original frontal hairline, the approximate coronal suture position estimated by surface approximation, the VTP, and the hair whorl. To our knowledge, the 10-10 system has not previously been correlated with a dermatologic scalp mapping framework. The correspondence is noted here both for orientation of readers familiar with EEG nomenclature and as a possible starting point for future cross-disciplinary or multimodal scalp imaging applications.

Although developed for trichoscopic documentation, the framework is anatomically rather than modality-specific and may be applicable to other scalp documentation needs, such as recording biopsy sites of cutaneous malignancies on the scalp and longitudinal monitoring of specific scalp lesions. The same labels can describe any imaged or biopsied scalp location, irrespective of imaging modality. These extensions are speculative and would require validation in the relevant clinical contexts.

Several limitations should be acknowledged. The framework assumes reasonably symmetric anatomy and is not intended for focal lesions outside the standard grid, for which freeform description remains appropriate. It has been used to document approximately 150 patients with hair loss in our tertiary referral hair clinic since 2025 but has not been formally tested for inter-observer reproducibility; a multi-centre validation study would be a useful next step. The proposed point spacing and regional dimensions are practical conventions derived from routine clinical workflow and informal bedside measurement rather than formal anthropometric study, and optimal spacing may differ in patients with smaller scalp diameters or extensive alopecia. The VTP and the approximate coronal suture position are observer-dependent, which is acceptable for a clinical labeling system but would require careful operationalization in any formal reproducibility study. F0, the original frontal hairline, is likewise an estimated rather than a palpable landmark in patients with recession; expert identification of the original hairline is imperfectly reproducible and is more difficult in premenopausal women and in patients with skin of colour, although simple standardized guidance improves agreement [18]. Because F1 is anchored to F0, this uncertainty propagates to F1 in patients with substantial recession. In severely bald patients, hair-bearing landmarks such as the hairline are absent or significantly shifted; in these cases, the framework relies more heavily on bony landmarks (inion, superior temporal line, the nasion-opposite plane) and on the position of remaining hair-bearing scalp. F0 remains available in principle but is less reliably identified in this setting. The proposal addresses location labeling only; image quality factors such as lighting, magnification, and the choice of polarized versus non-polarized dermoscopy are out of scope and should follow standard trichoscopic technique.

6. Conclusions and Prospective

Standardized anatomic points and labels for clinical trichoscopy remain an unmet need in hair-loss practice. The framework proposed here pairs a defined set of anatomically anchored imaging points with a short alphanumeric shorthand for direct EMR entry, is quickly learnable (summarized in Box 1), and is intended to complement existing sampling protocols [3]. Useful next steps include a multi-centre inter-observer agreement study to test reproducibility of both the points and the labels, a comparison of structured labeling against free text for longitudinal documentation efficiency, and refinement of disease-specific imaging templates through broader clinical input. We hope this proposal prompts further discussion toward a consensus standard for clinical trichoscopic scalp mapping and labeling.

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Institutional Review Board Statement

Ethical review not required as it did not involve human participants or identifiable data.

Informed Consent Statement

Not applicable; this study did not involve human subjects.

Data Availability Statement

All relevant data supporting the findings are included within the article.

Conflicts of Interest

Given the role as Editorial Board Member, Eunice Y. Chow had no involvement in the peer review of this paper and had no access to information regarding its peer-review process. Full responsibility for the editorial process of this paper was delegated to another editor of the journal.

Use of AI and AI-Assisted Technologies

During the preparation of this work, the author used Claude, Sonnet 5 (Anthropic) to assist with language editing, readability, and proofreading of the manuscript text. The author reviewed and edited all AI-assisted content and takes full responsibility for the contents of this publication. No AI or AI-assisted tools were used to generate or alter the figures, tables, data, or scientific content of this work.

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