

forum

Volume 13, Number 6

November/December 2003



**50 Years
Later**

(Pioneers are in bold, others are past Presidents of the ISHRS. Dr. Norman Orentreich was present for Friday's panel, but was unable to attend Saturday for the awards.)

Bottom row: Drs. Tom Alt, Bluford Stough, O'Tar Norwood, Walter Unger

2nd Row: Drs. Robert Berger, Richard Shiell, Bob Haber

3rd Row: Drs. Jay Barnett, George Farber, Patrick Rabineau, Hiram Sturm

4th Row: Drs. Russell Knudsen, Shelly Kabaker, Bobby Limmer, Marcelo Gandelman, Dow Stough, Jim Vogel, Paul Straub, Bob Leonard

On Friday, October 17, the ISHRS was treated to a panel, the likes of which has never occurred nor will likely occur again. The man who founded the procedure that governs our field, Dr. Norman Orentreich, and 10 of the men who were integral in developing hair restoration and educating the world, were present on stage. After introductions, they shared some of their thoughts and some history with us in a moment to be remembered. The panel consisted of Drs. Tom Alt, Jay Barnett, Robert Berger, George Farber, Norman Orentreich, O'Tar Norwood, Patrick Rabineau, Richard Shiell, Bluford Stough, Hiram Sturm, and Walter Unger. Dr. Sam Ayres III was also honored but was unable to attend.

1. Tom Alt. Dr. Alt got his start in transplanting in 1972 following visits to the offices of Drs. Blu Stough, Jim Burks, and Norman Orentreich. He became a prolific writer and lecturer, and was a dominant figure in the American Society of Hair Restoration Surgery. Currently he is retired and enjoying life in Minnesota.

2. Sam Ayres III. Dr. Ayres began hair transplanting in the early 1960s and rapidly became a benchmark in cosmetic artistry. He became the "transplanter to the stars" in Hollywood, and was an early pioneer in the use of small grafts. Health reasons prohibited his attendance, but one of his successors,

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President: Mario Marzola, MBBS

Executive Director: Victoria Ceh, MPA

Editors: Michael L. Beehner, MD, and William M. Parsley, MD

Surgical Assistants Corner Editor: Shanee Courtney, RN

Managing Editor & Graphic Design: Cheryl Duckler, cduckler@comcast.net

Advertising Sales: Cheryl Duckler, 847-444-0489; cduckler@comcast.net

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The ISHRS Golden Follicle Award sculpture, as seen on the cover of this issue, was designed by Francisco Abril, MD. Dr. Abril offers for sale, copies of a small bronze hair follicle sculpture (10" high). For more information, please contact: Clinica Dr. Francisco Abril, PO dela Habana, 137, 28036 Madrid, Spain. Phone: 34-1-359-1961; Fax: 34-1-359-4731.



Mario Marzola, MBBS
Adelaide, Australia

It is 3 o'clock in the morning and I can't get to sleep. My wife and children are happily dreaming in our hotel room but the Gala Evening with all the beautiful feelings won't stop going around in my head. I'm talking about our 11th Annual Scientific Meeting of ISHRS at the Marriott Marquis Hotel in New York. I hope you were there.

Undoubtedly the best meeting ever, they just get better and better don't they? May I share with you some of the highlights. The program put together by Jerry Cooley asked for professional and scientific papers and in the 11 years of ISHRS I have never seen the presenters respond so well. Speaking for all the attendees, Jerry, I wish to thank you for the time and effort that I know you put into our program. You are a star.

The Distinguished Assistant Award was presented for the first time. Has anybody deserved it more than Cheryl Pomerantz and Marilynne Gillespie? Maybe just maybe the super important status of our surgical assistants is starting to be recognized. As an Australian, I was very proud of Jennifer Martinick's Platinum Follicle Award and cheered loudly when Bill Parsley's Golden Follicle Award was presented as it was well overdue. Who would argue with these choices? The ISHRS Executive Committee does not give the

Manfred Lucas Award every year but Walter Unger deserves to join the elite group for he speaks and writes so clearly that it is a pleasure to learn from him. To know that he is a gentleman and a devoted family man is just a bonus.

Who will ever forget all the Pioneers present? Tom Alt, Sam Ayres, Hiram Sturm, George Farber, Bobby Berger, Patrick Rabineau, Jay Barnett, Walter Unger, O'Tar Norwood, Richard Shiell, (Norman Orentreich was present earlier in the day), and what did you all feel when Dow Stough made that speech off the cuff about his dad, Blu Stough? I don't think there was a dry eye in the house.

I would really like to thank Bob Haber and Victoria Ceh for looking after the ISHRS as if it were their own. That is the way I hope we all look upon the ISHRS, our Society, full of our friends, looking for all ways to improve our patient outcomes while having the best time along the way. This is our life, it is not a dress rehearsal.

Please help me to run the ISHRS even better next year. There are many committees and positions on which to serve so let Victoria Ceh know at head office. Tell her you want to be involved to keep developing this great Society of ours. We need your input so please fax me at 630.262.1520, E-mail info@ishrs.org, or contact me at mario@marzola.net. ♦

Sincerely,

Mario Marzola, MBBS

Note to All Members

2004 Annual Membership Dues were mailed November 18. Payments are due by December 31, 2003. You may make payment online, via fax, or post.

Happy Holidays and Best Wishes for the New Year!

Co-Editors' Messages



William M. Parsley, MD
Louisville, Kentucky

The 11th Annual Scientific Meeting of the ISHRS has just ended and what an experience. To no surprise of those who know him, Dr. Jerry Cooley did a wonderful job of orchestrating the meeting, and of emphasizing the techniques and research of highest interest to the Society. Follicular unit extraction, perpendicular grafting, and new research were among the areas given ample attention on the program. Summaries of each day's program are elsewhere in this issue (most pictures and Awards will be in the next issue). Education was not confined to the lecture rooms, but also spilled into the hallways. Dr. Bill Rassman, always

inventive, was seen showing some doctors a new device that he hopes to showcase soon. It is an implanting device that sucks up the graft into a disposable needle; it then creates a site and ejects it into the recipient area. It is the new version of the Hair Implanting Pen (HIP) and it certainly looks promising; however, history has repeatedly demonstrated the obstacles along the road from the drawing table to the operating table for automated planting. If anyone can do it, Dr. Rassman will probably be that person. Meanwhile, Dr. Marc Avram demonstrated a magnifier utilizing a Polarized LED light. It is called the Syris and also seems to have much promise.

The highlight of the meeting for most of us was the Pioneers in Education panel. Eleven of the doctors who founded and taught hair restoration were gathered on one stage and introduced, along with some highlights of

their accomplishments. These included Drs. Norman Orentreich, Hiram Sturm, Bob Berger, Bluford Stough, Patrick Rabineau, O'Tar Norwood, Jay Barnett, George Farber, Tom Alt, and Walter Unger. Dr. Sam Ayres was also honored but was unable to attend. With Dr. Unger moderating, the panel turned out to be a trip down memory lane with each giving a little tidbit of history, ending with Dr. Orentreich describing his work that turned out to be the birth of modern hair restoration. It was coincidental that this was the Golden Anniversary of the first hair transplant performed by Drs. Orentreich and Sturm (late 1952) and was within a mile or so of the place it was performed. Saturday night at the Gala Dinner, the honorees were given an award, highlighted by Dr. Dow Stough giving the award to his father, Dr. Bluford Stough. Dr. Jay Barnett

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Michael L. Beehner, MD
Saratoga Springs, New York

New York Meeting

The depth and breadth of knowledge presented at the recent annual ISHRS meeting in New York was truly awe-inspiring. It makes me feel

fortunate I am not entering the field at this time, as I may have been scared away by the complexity of it all, and all the seemingly conflicting methods for accomplishing the same goal, namely, the simple task of placing hair on a balding scalp. Hats off to Dr. Jerry Cooley for organizing and pulling off a fantastic meeting! The support of the membership, with the high attendance numbers, also speaks well for the strength and vitality of our Society.

First IBHRS Exam

On Sunday afternoon, after the meeting's conclusion, the first three international candidates took the IBHRS written and oral exams. I am pleased to announce that all three passed. Tentatively, it is due to be next offered this coming March in Orlando, Florida, in association with the annual ISHRS Live Surgery Workshop (ABHRS exam will be offered also).

Original Okuda Papers

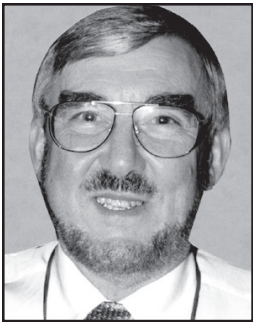
One of the highlights of the meeting for Drs. Bill Parsley, Richard Shiell, and myself was Dr. Imagawa sharing with us an exact duplicate of the original papers written by Okuda in Japan in the 1930s, along with an English translation by Dr. Imagawa himself. In a future issue of the *Forum*, Dr. Shiell will be sharing some of the highlights from this text with the readership. It makes for fascinating reading, especially in light of how many decades it preceded our current state of the art.

On Transplanting Areas Other Than Male Scalps

I was reflecting the other day on the fact that I find my hair transplant practice all the more interesting because I do other things besides simply transplant males who are losing their hair on top. And yet, these other procedures—eyebrows, temple work, transplanting of females and trans-gender patients—are all somewhat riskier to take on in the early years of one's practice. My advice to those starting out would be to avoid these in the early years, watch several experts perform them many times, and then cautiously get started in these areas on ideal candidates. In each of these types of surgery, there are lots of would-be candidates who should probably not be attempted, even by so-called experts. Especially with regards to transplanting the anterior temple and eyebrow areas, the grafts are very much exposed and have to look exceedingly natural. Angulation is very key, along with controlling the direction of the curl of

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Notes from the Editor Emeritus



Richard C. Shiell, MBBS
Melbourne, Australia

Pioneers Article

I was greatly flattered by Dr. Mike Beehner's article about me in the last issue of the *Forum*. Such articles are usually only published after one is dead, and

it is a humbling experience to read such stuff during one's actual lifetime. Anyway, it has been an honour to serve the members of our Society and to try and pass on some of my knowledge and enthusiasm for this field to our younger members.

New York Meeting

This meeting concluded a few hours ago and I am rushing a few comments into the *Forum* before it goes to print. Much more will undoubtedly be published in editions 1 and 2 of 2004, but let me preempt these by saying that I think that this meeting was, in my mind, the best ever and a fitting conclusion to the outstandingly successful year of ISHRS President Dr. Bob Haber. The attendance was the third highest ever, and Dr. Jerry Cooley, Chairman of the organizing committee, and his legion of helpers are to be congratulated.

The program was full of interest and ran like clockwork. There was seldom a subject without appeal, although I noted with regret that any talk of flaps or reductions was guaranteed to send 200 participants to an early coffee break and lectures on genetics and medico-legal topics produced a similar rapid thinning of the audience ranks. I urge future meeting conveners to persist with these important subjects, however, as "popularity" should not be the only criteria for staging important topics. If our meetings are to continue to have scientific status and CME accreditation, important but less popular topics such as genetics, scalp reductions, and artificial hair implants should continue

to be listed along with "sexier" subjects such as finasteride and FUE.

Highlights

In the brief space available in these notes, I would like to mention my highlights of the meeting. First was the extraordinary display of fine work in the Live Patient Display. Every one of the more than 25 patients on display served as a reminder of how far we have advanced in our craftsmanship these past few years. It is so gratifying to find that these skills, once restricted to a few masters, are now becoming more widespread in our ranks.

My next highlight was the assembly of the Pioneers of Education on Friday afternoon. It was a great achievement to gather these 11 individuals together in New York as only 3 of us (Walter Unger, O'Tar Norwood, and I) are members of the ISHRS. I was honored to be included amongst the ranks of such HT luminaries such as Drs. Norman Orentreich, Hiram Sturm, Jay Barnett, Bob Berger, Blu Stough, Sam Ayres III, George Farber, Tom Alt, and Patrick Rabineau who, with over 40 years of experience, were all my mentors some 36 years ago when I commenced hair transplantation. It is humbling to find that Norman (now 82), George, and Patrick, although well into their 70s, are still in practice.

It was gratifying to hear from Drs. Walter Unger, Bill Reed, Vance Elliot, and others that grafts larger than FUs still have a place in their practice. I suspect that these carefully cut, multi-unit grafts may even be on the verge of a comeback as their cost-effectiveness is better appreciated. Scalp reductions still have a few faithful adherents and Frechet Flaps are alive and well in the capable hands of Drs. Patrick Frechet and Daniel Didocha.

Awards

Saturday evening was the usual happy occasion with the highlight of the night being the presentation of the new (and long overdue) Distinguished Assistant

Awards to Cheryl Pomerantz and Marilynne Gillespie. We were equally delighted to celebrate Walter Unger's Manfred Lucas Award for his 36 years of service to our profession that included innumerable papers, book chapters, and 4 textbooks. The Golden Follicle Award went to our popular Editor, Dr. Bill Parsley, for his 30 years of service and Dr. Jennifer Martinick, our first female recipient, was voted the Platinum Award for her consistent and ongoing scientific research.

Finally, it must have been gratifying for the meeting organizers and speakers to find an unusually large audience of more than 150 participants still in attendance on Sunday morning to hear the concluding lectures. A great improvement on the 50 or so at some past meetings.

Grants

We were extremely disappointed to receive only 4 applications for Research Grants this year, the lowest number on record. Does this mean that you have all given up on research or are you all too affluent to bother filling out the application form? As we had \$6,000 to spend, all applicants received some support this year. Please remember to apply for a Research Grant next year. Every application is carefully considered by the Committee.

Japan Trip

I had a pleasant and instructive trip to Japan in late August to inspect the Nido artificial hair factory and clinics. I did this in the company of local HT surgeon Dr. Kenichiro Imagawa, who has given a number of talks on the complications of artificial hair implants. The Nido management and staff were very friendly and cooperative, and answered all our questions quite openly. The Report of our trip has been passed on to the Ad Hoc Committee on AH Chaired by Dr. Martin Unger. Recommendations will be made to the ISHRS Board as to whether we should continue to permit

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HAPPENINGS FROM...



New York, New York

THURSDAY, OCTOBER 16, 2003 • DAVID PEREZ-MEZA, MD MAITLAND, FLORIDA

The “Big Apple”—“The city that never sleeps”—was the perfect location for our 11th Annual ISHRS Scientific Meeting.

As David Letterman would say: “Our top 10 list of reasons for holding the meeting in NYC would be: 10—Great plane and hotel deals. 9—Nightlife, shopping, and Broadway plays. 8—Bald cab drivers wearing turbans. 7—Prospective clients on every street. 6—Statue of Liberty. 5—Latest Hollywood-style hairpieces. 4—Cheap Chinese food and Rolexes. 3—Meet Dr. Norman Orentreich. 2—Latest ‘Queer Eye Meets the Straight Guy Hair Techniques.’ And the #1 reason—Best flea market in the world to purchase old second hand punches.”

The day started early for me. As a faculty member of one of the Society’s fellowship programs, I attended the orientation for the ISHRS Fellowship Training Guidelines. This two-hour workshop was attended by 15 physicians interested in starting hair restoration surgery training programs. Dr. Carlos Puig, chairman of the fellowship training program, presented the guidelines and goals of this new program.

In Dr. Robert Haber’s presidential address, he mentioned that there are 1.2 billion people in the world with baldness and 52 million bald men in the U.S., with only 3% of those seeking some type of treatment. He pointed out that there is not a “unique technique,” but that there are different ways to treat patients. He emphasized the importance of *honesty and modesty*, and presented humorous skits of situations in hair restoration Hollywood style (video)!

Dr. Russell Knudsen pointed out that with the evolution of medicine we have several paradigms in hair restoration surgery, but “what is theory and what is reality?” Donor dominance (Orentreich, 1959)—Theory: Donor hair retains its characteristics and is unaffected by the

recipient site. Reality: Recipient sites influence growth rates of transplanted hairs (Hwang, 2002). He advised us to keep our debates scientific and rigorous, so that we don’t (yet again) prematurely discard a formerly valuable technique before proving the superiority of the “new” paradigm.

The experienced Dr. Richard Shiell spoke about the world of science and medicine, pointing out that we think that we have the full story about some new medication or technique, but we are often only seeing a poor reflection of the truth. As surgeons we need to read more, attend meetings, and take the Boards to be prepared for the future.

Dr. Carlos Puig presented the hypothesis that the hair restoration industry is on the cusp of real maturation and substantial market expansion. He pointed out that for most of the last 30 years the industry has stalled while serving less than 2% of the potential market. He proposed that in every instance there is a relationship between product reliability and expansion of the market. He suggested that the members of our profession work together to provide the market place with accurate information and reliable results from each and every hair restoration surgeon.

Achieving Density and Avoiding Poor Growth (Masters’ Panel)

Dr. Bobby Limmer noted the importance of having experienced assistants on our team, keeping the grafts hydrated, and placing the grafts in the recipient area with minimal trauma. He pointed out that 20–25 grafts/cm² can give good density, and the coverage of the frontal central zone is critical to camouflage any transparency in the hairline.

Dr. Walter Unger uses both the FUT and the “combination” approach of FUs and multi-FU grafts in his patients to

create the appearance of density. He recommends that 20–25 FUs/cm² be the limit of density and uses an 18-gauge needle for most of his sites. He feels that increasing the grafts/cm² would result in lower hair survival rates. What is important is not knowing how many hairs you transplant, but knowing how many survive.

Dr. David Seager enumerated the three principles that he considers most important: keeping the grafts moist, making recipient sites appropriate in size, and using the correct technique in dissecting the grafts.

In the opinion of Dr. Ron Shapiro, the most important aspects to achieving good density and avoiding poor growth are slivering with lateral tension under magnification; atraumatic placement of the grafts—matching graft size to the incision; and the aesthetic importance of density in the “frontal core” area.

Dr. Michael Beehner presumed that the previous speakers discussed the importance of the assistants and care of the grafts (he was correct). He spoke about the importance of including “combination grafts” in the transplant plan along with FUs. He noted that research to date shows the highest percentage survival rates in minigrafts, whereas that reported for FUs has varied greatly, but has been less than with the slightly larger grafts. He recommends finasteride to all his patients to optimize the appearance of the surgical outcome years down the road.

Our last speaker in this panel, Dr. Bill Parsley, gave us his three practical tips: Having the proper depth and diameter of recipient sites is critical, avoiding damage to the supra-galeal vascular plexus. Be patient and flexible during the surgery, especially when the tissue and grafts present difficulties (white hair, mushy dermis, etc.). Sometimes we have to try different site-creation

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HAPPENINGS CONT....

instruments to get better results in a given patient. He also recommended creating the recipient sites carefully to avoid transection of existing hairs, especially with current megasessions of 2,000–4,000 or more grafts.

Alopecia Reduction and Flaps

Dr. Patrick Frechet mentioned how the eight major issues related to alopecia removal and scalp flaps have now been solved in order to obtain a predictable safe, aesthetic, and permanent result. Dr. Shelly Kabaker spoke about the pros and cons of expanders and the advancement of skin flaps to help in lowering high hairlines in female patients. Such surgery normally saves the patient money and results are obtained sooner and in fewer sessions.

Hair Research

Man has been on earth for millions of years, and baldness has always been part of our existence. We can clone sheep, rabbits, etc. What about hair and baldness?

Dr. Conradus Gho from the Netherlands spoke about several of his studies, which show that follicular stem cells derived from plucked hairs can be cultured. He discussed the pros and cons of the technique, but reported that so far the results have not been satisfactory.

The featured speaker; Dr. Angela Christiano, a world-renowned researcher, gave us an update on hair follicle research (a detailed write-up will be included in a forthcoming issue).

Cell Therapy

Cellular therapy can be defined as the in vivo use of autologous, allogenic, or xenogenic cells for the prevention, treatment, or attenuation of different diseases. Like all new and emerging technologies, cell therapy has raised many hopes for the treatment of alopecia. The complexity and cost of these therapies are the future challenge.

Dr. Walter Unger noted studies on cell therapy in animals and humans, discussing many variables and explain-

ing that it is not easy to grow hair. The challenge for the future is the cost and finding sponsorship.

In his talk, "From the Laboratory to the Clinic," Dr. Bessam Farjo of Manchester, England, spoke about a clinical human trial on an "autologous hair regeneration product" called TrichoCyte. The principle is as follows: Cells from the patient's hair follicle dermal papillae are grown in culture and then transplanted back in the same patient's scalp, where they induce the formation of a new hair follicle. He pointed out the difficulties and complexity associated in starting such a trial, which is now in the early stages.

"Promises, promises, and promises" were the words stated by Dr. Ken Washenik in his lecture on cell therapy. Although research in this area and interest in its promise has blossomed recently, he emphasized that this idea has existed in scientific literature for decades and in the hair transplant literature for more than a decade. The challenges appear to be focused on hair follicle neogenesis.

Dr. Jung-Chul Kim from South Korea presented his study to identify the genes that can distinguish dermal papilla cells from the closely related dermal fibroblasts using DNA microarray. He found around 5,000 genes and mentioned that dermal papilla cells can act as hair and also specialize as wound healing cells.

The Cutting Edge I-II

In this session, Dr. Krugluger mentioned the improvements in storage solutions for hair follicle micrografts to reduce the apoptotic cell death, increasing hair survival and enhancing the clinical outcome of micrograft transplantation.

Ischemia-Reperfusion Injury (IRI) was discussed by Dr. Jerry Cooley, especially as it relates to storage solutions for grafts. He first presented his study showing that implanted grafts experience free radical injury (IRI). He then presented data from a recently completed study in seven patients looking at whether IRI can be prevented. He compared solutions for graft storage, normal saline control versus Hypothermosol (which contains

antioxidants), and found that the latter was associated with a 47% decrease in IRI damage. Dr. Cooley plans to study whether grafts stored in this solution have earlier, fuller, or more consistent growth.

Dr. Jung-Chul Kim next reported his results concerning the factors that affect graft survival. One of the factors is the use of multi-bladed scalpels that increase transection; others are crushing, squeezing, and bending the grafts; letting the grafts dry out; "out-of-body" time (longer time = less survival); temperature; and the use of hydrogen peroxide that has been controversial.

Dr. William Rassman and Robert True discussed different aspects of the follicular unit extraction.

Dr. James Harris presented the new term of Hair Volume Index (HVI) and its correlation to subjective visual hair density. He uses the hair shaft diameter (HSD) and number of hairs per cm² as parameters to obtain the HVI. Several patients with subjective evaluations of thin, medium, and dense hair were evaluated. He concluded that HVI less than 20/cm² gives a thin appearance, 30–40 moderate, and more than 60 gives a dense appearance.

I (David Perez) presented an evaluation of the hair shaft diameter (HSD), both before and one year after hair transplantation. Twenty patients were included and the digital micrometer was used for the hair shaft measurements. The results showed an average of 79.5 microns before and 84.1 microns one year after transplantation. A 10–18% variation was found in the diameters at three different areas of the hair shaft. It was concluded that there is a minimal HSD variation before and after transplantation, and that difficulties exist in measuring HSD in individual hairs. A better method of measurement is needed.

Dr. William Reed presented the frequency of telogen in the donor scalp and its implications. Two hundred hair follicles from 12 patients were photographed and assessed to determine the frequency of telogen hairs. He found less than the expected 10–15% telogen hairs, and concluded that the missing percentage represented invisible "exogen" hairs.

Dr. Tania Pauls presented the practical Mayer-Pauls Scalp Elasticity Scale in a study of 127 patients. She mentioned that the elasticity of the scalp influences the upper limits of donor tissue that can be safely excised with minimal scarring.

The physics aspect and computer simulation of scalp blood supply were

presented by Dr. Arthur Tykocinski. He pointed out that for greater survival rates in FUT, small incisions should be made, keeping incision direction the same and preserving the deep vascular bundle.

Congratulations to our Program Chair, Dr. Jerry Cooley, and Executive

Director, Victoria Ceh—both did a great job. After everything is over and done, I slowly begin to assimilate our New York mental makeover in extreme hair restoration. I am ready along with all of you for the Vancouver Hairtrix reloaded. I hope I haven't been "Lost in Translation."



FRIDAY, OCTOBER 17, 2003 • BESSAM FARJO, MD MANCHESTER, UNITED KINGDOM

The second day started with a "Back to Basics" session. Dr. Ivan Cohen addressed the problems when a woman's hair loss can masquerade as AGA. Differential diagnoses include telogen effluvium, trichotillomania, alopecia areata, and lichen planopilaris. He suggested a biopsy followed by a year of inactive disease before considering a transplant. Test grafting would also be a good idea. Another entity confused with AGA is Fibrosing Alopecia in a Pattern Distribution (FADP). This scarring alopecia was discussed by Dr. Bernard Nusbaum highlighting its similar pattern and histological findings to AGA.

Dr. Ken Washenik reported on the Prostate Cancer Prevention Trial using finasteride that included 18,000 men over the age of 55 with half given 5mg daily finasteride and the other half given placebo. There was a 25% reduction in the prevalence of prostate cancer, but of the ones who got cancer, 10% were of the higher grade. Dr. Washenik also reported on a study using combined finasteride and minoxidil therapy. Using global photography but no hair counts, there was a statistically significant advantage in using both drugs together.

Dr. Julianne Imperato-McGinlay gave a fascinating account of her involvement in identifying the syndrome of 5 alpha reductase type 2 deficiency in a Dominican Republic community. This consequently led to the understanding of the role of this enzyme in the body. Dr. Paul McAndrews emphasized the important role of medical therapy for hair loss by comparing it to using toothpaste to prevent tooth decay! Dr. Valerie Callender shared her experience in transplanting African American women

as an option for the treatment of traction alopecia and central centrifugal scarring alopecia (CCSA). Adjuncts for treatment include camouflage, medical treatments, and, where indicated, topical or intralesional corticosteroids. Her tips for keloid prevention included doing a test HT if CCSA is diagnosed, using corticosteroids and Bacitracin on day 1 of HT and corticosteroids for the donor site on day 14.

Dr. Matt Leavitt presented the findings of a study on the effect of finasteride before, during, and post transplantation. Although there was a statistically significant increase in hair counts, this was thought to be likely in decreased telogen of the non-transplanted hairs. Dr. Martin Unger reported on the "lasercomb" with what appears to be amazing results showing 100% stabilization of hair loss in both men and women in a Canadian study.

Highlights of the session on practical tips included Dr. Paul Rose's presentation of his study comparing complete microscopic dissection versus only using the microscope for the slivering part with simple magnification and back-lighting for the FU separation. He concluded that total use of the microscope does not seem to offer a significant difference in terms of the quality of the FUs. Dr. Sungjoo Hwang presented his 20-month results of the recipient dominance study. He used different parts of his body as recipient sites and concluded that survival rate is dependant on skin thickness and vascularity, and some new hair growth was observed 16 months after HT. Hair shaft diameter was not affected.

Dr. Cam Simmons reminded us that supraorbital and supratrochlear nerve blocks can still be a valuable adjunct to

scalp anesthesia. He demonstrated this with a study he conducted with Dr. David Seager. Dr. Marc Avram presented his 8-month experience with the Syris polarized magnifier on the recipient scalp. Among the benefits are better vision, less heat, and less damage to existing hair. Dr. David Perez-Meza reported on a study of 40 patients using 4/0 Vicryl Rapide fast absorbing suture for closing the donor with excellent results, demonstrating less tissue reaction than others. I have been using this suture for a while now and have been very happy with it. More recently I switched to 5/0 Vicryl Rapide on most patients with no deep sutures. Dr. Jerzy Kolasinski claimed the crown of fastest hair man in the west (and the east!) with his "four-hands-stick-and-place technique." A variation of the original Uebel technique, it takes him only 1.5–2 hours to do 1,000 grafts and up to 4 hours for 2,000 grafts! Dr. Dow Stough suggested keeping your patient comfortable with adequate hydration, snacks, and periodical mobilization of the patient.

The afternoon session began with papers on complications, a good learning experience for both beginners and experienced surgeons in methods of dealing with some common and not so common problems associated with hair restoration surgery. Dr. Tony Ruston from Brazil presented two cases of post-operative recipient area necrosis in heavy smokers. They also developed hair loss above the donor scar. He eventually excised the necrotic scalp and treated the donor area with Minoxidil. Two cases of AV fistula and pseudoaneurysm were presented by Dr. Nicolas Lusivic. Each presented as pulsatile mass and treated by ligation

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MESSAGE FROM THE PROGRAM CHAIR



Dear ISHRS Members and Colleagues:

I want to remind everyone that next year's Annual Meeting in Vancouver, BC, Canada is three months earlier: **August 11–15, 2004**. Vancouver is a beautiful city, and the theme is fresh air and fresh ideas in hair restoration. While the New York meeting is still fresh in your mind, please e-mail or call me with any ideas or suggestions for next year's meeting.

The Call for Abstracts will be sent out in November. As we are losing three months of preparation time, it is essential not to delay or procrastinate. Some of the preliminary feedback from New York included a request for more audience participation in the form of Q&A sessions and panel discussions on controversial topics with the leading innovators in our field. The Beginner and Advanced Courses were well attended, and are a great learning opportunity for our surgical assistants. I am planning more hands-on and one-on-one interactions via breakout workshops and the "breakfast with the experts." I would also encourage more video movie inserts to reinforce presentations demonstrating surgical techniques.

On a more personal note, Vancouver and the Pacific Northwest is a scenic area boasting beautiful parks, excellent restaurants and shopping, and many outdoor activities including fishing and hiking. Alaskan cruises and tours are not far away, and this is an excellent opportunity to incorporate a family vacation into this wonderful educational experience.

Please e-mail me at esehairmd@verizon.net or call my cell at 757-748-8040. Let's make Vancouver a wonderful educational experience.

With warmest regards,

Edwin S. Epstein, MD

Richmond, Virginia

Chair, 2004 Annual Scientific Meeting Committee

**Call for Abstracts
submission deadline:
February 1, 2004**

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Pioneer of the Month

Masumi Inaba, MD

Richard C. Shiell, MBBS *Melbourne, Australia*

I have always been conscious of the omission of our Japanese brethren from this section of our journal, and I would like readers to know that the omission is not deliberate. The reason is that I have found it near impossible to gather the material on early Japanese pioneers in hair surgery such as Drs. Sasagawa, Okuda, Tamura, and Fujita who published, mostly in the Japanese language, over 50 years ago. Ernest requests to each incoming President of the Japanese Society of Hair Replacement Surgery have been without result to date.

In desperation, I have decided to start with my good friend, the late Dr. Masumi Inaba, and hope that this little biography will stimulate further contributions from Japan. At the time of his death in 1998, I was unable to get any detailed information about Dr. Inaba so, for the July 1998 Forum, we compiled his obituary from details on his book covers and recollections from his international friend¹. I would like to thank Dr. Inaba's son, Yoshikata, for supplying me with the additional information from which I was able to write the small essay below.

Dr. Inaba's name has been mentioned again in the last year or two as the originator of the follicular extraction method. I alerted Dr. Bill Rassman to his method of hair extraction after I heard he was investigating the newly popular Woods method, and this became the basis of his eventual FUE method. —RS

Masumi Inaba was born in Tokyo, Japan, in 1925. His father was a carpenter and he was the third son in a family of five children. He was a diligent student and went to the private High School affiliated with the Nihon University in Tokyo. From there, he went on to the Showa School of Medicine where he graduated in 1949 at age 24. Initially he was too young for War service and later, as a medical student, he was exempt from the draft.

Masumi had intended to become an Orthopaedic surgeon and completed postgraduate studies in that field, but during his studies he switched his attention to Obstetrics. Japan was experiencing an unprecedented birth rate and the demand for Obstetricians was at an all-time high. He completed his PhD studies in 1955 with a thesis on the Rh-antibody relationship between mother and child. He then opened his own small Clinic specialising in Obstetrics and Orthopaedics, and worked very hard caring for women and delivering babies for the next 20 years.

Career Change

One of his friends had a daughter who was troubled by persistent underarm body odor (bromidrosis), a condition quite intolerable in Japan. The existing surgical management involved the removal of the entire axillary skin

with its hair and sebaceous and sweat glands. The area containing apocrine glands was often large so the procedure could be incomplete. In addition, it left severe scarring.

Dr. Inaba wanted to help patients who had their work and social life restricted by bromidrosis. He applied himself to improving this procedure and developed a subcutaneous tissue shaving method that removed the apocrine and eccrine glands but spared the axillary skin. He got this idea from a wood planing machine that he had seen in operation at the workshop of a carpenter. The instrument took four years to develop and patent but it became the basis for his remaining lifework.

The method was extremely successful and he was gradually able to leave Obstetrics and specialise totally in the management of bromidrosis. He opened the Tokyo Research Centre for Hircismus in 1965, and over the next 20 years he performed his Inaba Method on over 50,000 patients with outstanding success. In 1979, he was awarded the highest honors by the Japan Medical Association for his work. He wrote dozens of scientific articles in Japanese and English with Japanese collaborators including his son Yoshikata. His textbook *Human Body Odor* was published in English in 1992.²

In a follow-up of his patients, Dr. Inaba noticed that axillary hair often regrew even though the follicular bulbs had been removed. Further microscopic examination revealed that regrowth regularly occurred as long as the duct of the sebaceous gland was preserved. He interpreted this to mean that the hair follicle stem cells resided in the vicinity of the opening of the sebaceous gland secretory duct. He spent the next decade working on this and other theories related to hair growth. He published a volume titled *Can Human Hair Grow Again?* in 1985³ and his important book *Androgenetic Alopecia* in 1996.⁴

Dr. Inaba was the first President of the Japan Society of Hair Restoration Surgery when it was formed in 1994. In 1995, he was the first recipient of the Platinum Follicle Award, the highest honour for scientific research from the International Society of Hair Restoration Surgery.

Dr. Inaba was unwell for some years as a result of cancer, complicated by diabetes, but continued to work until the last few days of his life. He was working on the Japanese language edition of *Androgenetic Alopecia* at the time of his death on February 12, 1998, and this volume was completed and published by his son Yoshikata in May of 1999.

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Pioneer of the Month

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Some of Dr. Inaba's Theories Awaiting Confirmation

1. While the USA researcher Dr. George Cotsarelis identifies the "bulge" area of the follicle as the site of hair follicle stem cells, Dr. Inaba staunchly maintained that the stem cells were located at the sebaceous isthmus, which is located near the secretory duct opening of the sebaceous gland.
2. Dr. Inaba advocates an additional "isthmal" stage to the conventional three-stage hair cycle (anagen, catagen, telogen).
3. Dr. Inaba felt strongly that an increase in dietary animal fats in Japan since the end of World War II had led to an increase in baldness in young Japanese men. He attributed this to the saturated fatty acids producing an increase in the size of the scalp sebaceous glands.
4. Dr. Inaba developed his Paddy Leaf Tonic, which he claimed contained agents capable of deactivating 5-alpha reductase.
5. Dr. Inaba emphasised the importance of preserving the capillary microcirculation that exists below the papilla and is connected with another microcirculation within the pilosebaceous unit. In other words, he was an early advocate of keeping follicular units and their associated sebaceous glands intact.

Unhappy with the biopsy punch as a suitable method for extracting single-

hair transplants, he developed his own method that he first published in 1990.⁵ It was also described in his 1996 textbook *Androgenetic Alopecia* (pp. 238–44).

Personal Life

Dr. Inaba was married to wife Toshiko in 1957 and had a daughter Yuko born in 1958 and a son Yoshikata (now a dermatologist and cosmetic surgeon) in 1959. There are now three grandchildren. He was immersed in his work and, in addition to family interests, he particularly enjoyed world history and travel. He also had a deep appreciation of oriental painting and chinaware. I have a magnificent antique scroll of bamboo, pinecones, and cherry blossom above my desk that he presented to me in 1996 when I delivered the keynote address to the JSHRS Annual Meeting.

Masumi liked to preserve some of Japan's finest traditions and practiced kendo (Japanese sword fighting using bamboo staves). He took great pleasure in dressing in his kimono and performing the Japanese Tea Ceremony in a traditional teahouse that he constructed on the roof of his Tokyo penthouse. One of my most treasured memories is climbing through the tiny entrance of this exquisite wood and bamboo building and sitting cross-legged on the tatami mat alongside Masumi. His daughter Yuko expertly performed the intricate movements of the ancient Tea Ceremony watched with pride by her mother and father.

GLOSSARY

Eccrine glands. Coiled secretory glands that open onto the skin surface and produce perspiration in humans.

Apocrine glands. Coiled glands ten times larger than sweat glands. They empty into the follicular infundibulum just above the entrance of the sebaceous duct. They are most densely situated in the axilla in humans.

Sebaceous glands. A holocrine gland producing sebum, which is discharged into the follicular infundibulum via the sebaceous duct.

Hyperhidrosis. Excessive sweating unaccompanied by offensive odour.

Bromidrosis. Excessive perspiration associated with an offensive odour emanating from the skin surface.

Incidence is approximately 10% in Japanese teenagers, higher in Caucasians.

Osmidrosis. Excessive odour from the apocrine glands without excessive sweating.

Hircismus. The general term for offensive body odour. ♦

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Beehner Message

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the hairs placed. With regard to transplanting women, the key to happiness on both the patient's and the doctor's part is communicating very realistic expectations, even perhaps setting the expectations a speck lower than is likely to occur. Once this is done, and assuming the woman has a sufficiently dense area of suitable donor hair, these patients are among the most grateful of all your patients. Women have made up 15% of our practice for the past several years and

my enthusiasm for transplanting them remains as high as ever. Eyebrows are a very special challenge. Many of us have observed Dr. Marcelo Gandelman performing his masterful surgery at the Live Surgery Workshops over the years. The varying angles over the entire eyebrow and the control of the hair's curl are the keys to good work in this area. Dr. Gandelman guided me (by e-mail) through my first eyelash case, but I decided, after it was all over and done,

that I would leave that particular procedure off my menu of services. So, the bottom line with all of these non-mainstream transplant tasks is to proceed slowly and cautiously, with as much knowledge and observation of others as possible, and you will be rewarded with the special satisfaction of helping these particular types of patients and also enjoy a breaking from your usual routine of transplanting male alopecic patients. ♦

Michael Beehner, MD

Puzzle Technique to Place Follicular Micrografts

Emilio Villodres *Barcelona, Spain*

In the past two years we have changed the way we place FU grafts during hair transplantation. The idea arose from a conversation with Dr. Arturo Sandoval at the Barcelona meeting in June 2001.

Since that time, I divide the receptor area into small square areas with an eye pencil. First I draw the external limits, then one vertical line that gives 2 areas, one horizontal line that gives 4 areas, and so on until I achieve as many squares as needed. Usually I like to place 40 FUs in every square, so I divide the desired total number of FUs by 40. For instance, if I place 800 grafts, I will need 20 squares—if I have

2,000 grafts, I will need 50 squares drawn with the eye pencil.

After we have finished drawing, we start placing the FUs square by square using a stick-and-place technique, going from down to up in order to prevent popping. Before starting, we infiltrate every square with saline containing 1:50,000 epinephrine. It takes us about 10 minutes to insert the 40 FUs into a square; then we infiltrate the next one and start placing until we have completed all the squares.

Using this method of placing follicular micrografts, we are faster than when using our usual technique of creating all

the incisions in advance. There are two reasons for this:

1. Trying to find all the incisions often costs us time.
2. After the first 30 minutes, hemostasis was not as good and caused difficulty working.

With this technique, we now perform one megasession of 2,000 FUs in 4 hours with 3 people placing, 2 of them at same time; and 2 more nurses creating FU grafts from the donor strip. Before starting this technique, we spent 6 hours placing the same number of grafts. ♦

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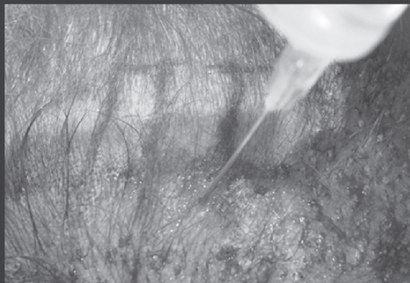


Figure 1. Stick-and-place infiltrating saline with white skin ready to be transplanted with good hemostasis.

HOMEOSTASIA WITHOUT PUZZLE. WELL FOR 30 MINUTOS, BAD FOR 90 MINUTES



Figure 2. The former all incisions with bad hemostasis after 30 minutes.

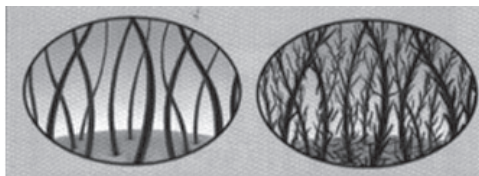


Figure 3. Before and after: patient with 4,000 FUs in two sessions.

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CYBERSPACE CHAT...

Please send your
comments/questions to:

esehairmd@mindspring.com



This will be my final Cyberspace Chat column, as I will be devoting full attention to my responsibilities as the Program Chair of the 2004 ISHRS Scientific Committee. Your comments to this column are the fastest method of sharing new ideas and posing solutions to everyday problems. I would like to encourage all ISHRS members to actively participate in the Cyberspace Chat column. Listed are three topics for which I would appreciate your comments:

1. What is your experience with the results of lateral or coronally placed grafts vs sagittal incisions?
2. How do you charge: by the graft or by the area? Pros and cons of each?
3. What size grafts do you use in the African American patient ("crispy hair")?

EPINEPHRINE REBOUND

Mike Beehner, MD
Saratoga Springs, New York

As I work at my desk while my assistants are battling with one of those "poppy-oozy" patients, I thought I would share my observations. When my team completes a procedure in less than 5 hours, we rarely encounter the "oozy" problem, unless it's one of those muscular gym rats. But when it goes over 5 hours and especially 6, we very frequently get what I am sure is "epinephrine rebound." We commonly use a saline solution of either 1:125,000 (all repeaters and all females) or 1:100,000 (first-timer males) as a working solution to tumesce our recipient area as we do the procedure. When we do 2,000–2,200 FU cases, I borrow a page from Dr. David Seager and divide the case into two, almost as if it were two patients. I take out half of the donor hair and transplant the front half of the area being worked on, only tumescing this area and not the area in the rear half. Then I remove the remaining donor hair and work on the rear half. This has worked for me to avoid the epinephrine rebound phenomena. I also resort to "super juice," probably around a 1:40,000 solution in our hands, and it helps a little, but is certainly no miracle

worker. There does seem to be a slight refractory nature to the problem once you get past that 5 hour point.

Jerry Wong, MD
Vancouver, Canada

In big cases exceeding 4,000 grafts, I start in the crown with the patient prone. The whorl and posterior region usually require approximately 800 grafts. The area is tumesced with 1:40,000 epinephrine. After this area is implanted, the patient is turned to a supine position, and the hairline and front 1/3 are tumesced. Another 2,200 slits are made in this area. Once these slits are filled, the mid-scalp is then tumesced and the remaining slits made. Epinephrine is given in three or four spaced out periods.

GRAFT TRIMMING AND SEBACEOUS GLANDS

William Parsley, MD
Louisville, Kentucky

Movement seems to be shifting back towards smaller, tightly trimmed grafts. How important are the sebaceous glands, and if they are prominent, should they be trimmed to make the graft smaller? We have been keeping our sebaceous glands intact. However, hair grows great in kids, and their sebaceous

glands are relatively inactive. Also, ketoconazole shampoo is supposedly effective because it kills yeasts and spores, which feed on sebum (even though its true mechanism of action is not really known).

Another concern is that by trimming the sebaceous gland, sebum (a foreign body) would logically spill onto the graft. Most would be cleansed by the saline, but could a reaction occur?

Francisco Jiménez Acosta, MD
Las Palmas, Spain

It is interesting to note that at the upper isthmus level, the sebaceous glands surround and penetrate in between the hair follicles of the follicular unit. For this reason, I do not think that even doctors that thinly trim the grafts can get rid of the sebaceous glands. I am sure those trimmed FU still contain significant portions of sebaceous glands. So, I do not find there is a problem with the trimmed grafts.

Bobby Limmer, MD
San Antonio, Texas

As you know, I have been a mild proponent for relatively close trimming to facilitate ease of dense packing. I cut all eyebrow grafts myself and they are very closely trimmed so they can go

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Cyberspace Chat

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into 23–25 gauge needle holes. I have noted neither cyst formation, pustules, nor failure to grow with this process.

William Rassman, MD **Los Angeles, California**

Trimming of the sebaceous gland may make the grafts more sensitive to drying, and therefore expose the area of the stem cell to a higher probability of damage. I know that many people who trim closely have a cut and insert system to account for and to minimize such potential damage.

James Arnold, MD **Saratoga, California**

In Dr. Jung Chul Kim's initial transsection study, he transplanted both halves of divided hairs to his leg. The hairs were divided just below the sebaceous glands, i.e., the upper halves had the gland and the lower halves did not. As you know, both halves were able to regrow a hair, a phenomenon considered so remarkable at the time as to be closer to magic than science.

About a year after the hairs had grown, Dr. Kim removed all the halves for microscopic review. He discovered several of the lower halves had regrown sebaceous glands. Dr. Kim showed a photo of a regrown gland at several meetings. Most people seemed disinterested in this new finding. After all, hair is the measure of our success, not glands.

TRANSPLANTING THE VERTEX

Dow Stough, MD **Hot Springs, Arkansas**

The progressive nature of hair loss is well known to all transplant surgeons. Yet, how many patients do we see day after day who have been transplanted in the vertex area, and now have a cosmetic result that is worse than the original balding condition? They can be repaired (temporarily), but the clock is still ticking on hair loss. It seems such a big gamble to tackle vertex alopecia below age 50.

I quit transplanting vertex alopecia in the late 80s /early 90s. Yes, there are

exceptions, but they are few and far between. Why any surgeon believes one can transplant the vertex with complete impunity is unknown to me. This is not a total condemnation of vertex transplantation. But, the routine cavalier approach bothers me.

William Parsley, MD **Louisville, Kentucky**

My line is at 45 years of age and only if the donor site is still rich and the junction between the bald skin and hair is abrupt. Also the parietal humps are important. The idea that the vertex is safe to plant in young people is still one of our main problems. Another is the delusional concept that we can predict that a patient's hair loss is stabilized. In truth, it is probably never stabilized, with the possible exception of medical therapy help. I just read an Internet entry 2 days ago from a 22-year-old male who was a NW5 with poor donor hair. He said that he wanted to hold off transplanting another 3 or 4 years, for when his hair loss is stabilized. The sad thing is that some transplanters might agree with him.

Carlos Puig, DO **Houston, Texas**

Crowns must be treated with the same aesthetic sensitivity as hair lines. Since going to FU transplanting, I never use grafts in the crown larger than 1–2 hairs. I always advise patients that they will lose more hair and our treatment goal is not total coverage but is maintenance of the "balding" look rather than the "total bald" look. For the past 7–8 years, my crown reconstructions leave the center thin or empty, with more grafts in the perimeter of the crown, building from the outside in, with attention to recreating the crown swirls by pointing the incisions to a planned, often off-center, single point. Often, I'll do nothing in the very center.

CORONAL INCISION NOMENCLATURE

Jerry Wong, MD **Vancouver, Canada**

Coronal is an adequate description of lateral slits. Perpendicular slit is a better description because the slits are always perpendicular to the direction of hair flow. Compared to the direction of the coronal and sagittal sutures, most slits will be coronal, some will be sagittal, others will be somewhere in between. I personally prefer lateral because it's easier to say than perpendicular. Makes no difference what it is called, as long as we're aware that it's the *hair flow*, not the coronal and sagittal sutures, that determines the incisional plane.

MICROSCOPES vs LOUPES

Brad Wolf, MD **Cincinnati, Ohio**

There is a relative paucity of objective studies in hair transplantation, but I do recall the studies done by Drs. Bernstein and Rassman, which showed increased graft numbers when using microscopes. Over the years as I increased the number of microscopes and power of magnification, I noticed the number of grafts from a strip increased. A follicular unit cut without any magnification can look as good, identical, or even better than one cut with magnification. But that's not the criteria that should be used—an increase in the number of preserved follicles is. What is being lost isn't being seen because it can't be seen without higher powers of magnification and it's in the garbage. If one believes these studies and the experience of those who have seen the light by not using higher powers of magnification, one is committing follicular homicide. This is not in the best interest of the patient, regardless of the cost to the physician and patient in money and/or time. In the past, one could argue that not using magnification didn't really make a difference because we didn't know. That is no

longer true so there is no excuse in my opinion. There are ways to magnify without microscopes but I found increased graft numbers going from loupes to 6× magnification and even more from 6× to 10× magnification. I prefer cutting slivers and the grafts from the slivers with magnification. No assistant has 6× eyes regardless of gender or ethnicity.

FINASTERIDE IN HEPATITIS C PATIENTS

John Gillespie, MD
Calgary, Alberta, Canada

I have used Propecia® in Hepatitis C patients. Most of these patients smolder along for years and years with slightly elevated ALT levels. They should be cautioned about the theoretical problem but I think the risk is minimal.

Ken Washenik, MD, PhD
Beverly Hills, California

I am unaware of any actual contraindication to prescribing finasteride to a patient with Hep C. Although finasteride undergoes hepatic metabolism, I have not encountered any actual hepatotoxicity in my office or clinical trial patients. My recommendation would be to check with the patient's gastroenterologist and prescribe it with his clearance. I would start out with intermittent dosing and liver enzyme monitoring. When I became satisfied that his liver is tolerating finasteride, I would increase to normal dosing and decrease the liver enzyme monitoring.

Vance Elliott, MD
Edmonton, Canada

I have a patient who is Hep C positive and I have had him on finasteride for about 3 years. His LFTs are watched by his internist, who approved of the medication as long as it did not alter the LFTs. It has not, but I would clear the therapy with the patient's gastroenterologist to ensure they are watching for change.

Damkerng Pathomvanich, MD, FACS
Bangkok, Thailand

I have encountered 2 Hep C positive patients without elevated LFTs. Fortu-

nately, their baldness was limited to class III, and I elected not to prescribe Propecia at this time. Because these patients would have to take medication for life, my personal feeling is not to give Propecia.

TRICHOTILLOMANIA

Eric Eisenberg, MD
Toronto, Ontario, Canada

1. The diagnosis of trichotillomania is quite specific according to the DSM criteria.
2. The simple act of pulling ones hair is not synonymous with trichotillomania because there are a variety of circumstances in which this occurs.
3. There is often a narrow normal perimeter zone surrounding the plucked areas, especially when large areas of the scalp are affected.
4. There may be a predilection for the crown or parietal areas.
5. Eyelashes and eyebrows may be completely absent as a result of plucking, and pubic hair may be thinned.
6. College sample surveys suggest that 1–2% of students have a past or current history of trichotillomania.
7. A diagnosis of trichotillomania is not given if behavior is better accounted for by another disorder (e.g., delusion, hallucinations).
8. Body dysmorphic disorder is quite separate and distinct from trichotillomania.
9. The surface of the scalp usually shows no excoriations.
10. The trichotillomania self-help learning center is in Santa Cruz, CA (408-457-1004).
11. Therapy includes medications to

control the impulse behavior, behavior therapy, hypnosis, and shared experiences through support groups.

12. Clomipramine (an SSRI) seems to be more effective than desipramine in short-term treatment of trichotillomania, suggesting that antidepressants with serotonergic effects might be the most effective agents. However, two controlled studies of these agents have had negative results. There is sometimes a relatively rapid response to an SSRI that is then lost over time.
13. There are substantial differences between treating children and adults. For example, medications are not appropriate for treatment of the vast majority of infants and children with early onset hair pulling. ♦

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A Study Comparing Growth of "Intact" FUs and "Non-Intact" Grafts

Michael L. Beehner, MD *Saratoga Springs, New York*

Author's note: Many times over the past few years I have been asked for the reference for this study I performed in 1998, which was presented at two ISHRS annual meetings but never published. Below please find a summary of the setup of this study, its results, and the tentative conclusions that were made by this observer. —MLB

The exclusive use of follicular unit grafts has been adopted by more and more hair surgeons in recent years. This study was designed to determine if there was any special inherent benefit for growth to be found in the "intact" FU. To serve as a comparative graft, I chose to create "non-intact" grafts to compare them to.

In order for the following to be understood, I will try to make as clear as possible what these "non-intact" grafts are. The non-intact grafts compare exactly the same in numbers of hairs per graft as the intact FUs. The only difference is that each non-intact graft is made of parts of two adjacent FUs (see Figures 1, 2, and 3). In each of these two FUs that contribute either 1 or 2 hairs to this graft, a very fine vertical cut has to be made under the microscope between the hairs of that FU. The tissue that is present between the two FUs is included in the graft, so that it is in fact one unit, or one graft per se. As an example, a 3-hair non-intact graft would be composed of one hair cut away from a 2-hair FU and two hairs cut away from a 3-hair FU.

Study Particulars

The study was performed on three males. In the rear mid-scalp on each patient, two 1.5 × 2.5cm side-by-side rectangular areas were demarcated with tattoo dots at their corners. Within the "intact FU box" were transplanted 30 2-hair and 30 3-hair FUs. In the other box were placed 30 2-hair non-intact small grafts and 30 with 3 hairs apiece. Thus each study box comprised 150 hairs being planted (see Figure 4). Only "strong" appearing anagen hairs were counted, and an attempt was made to exclude

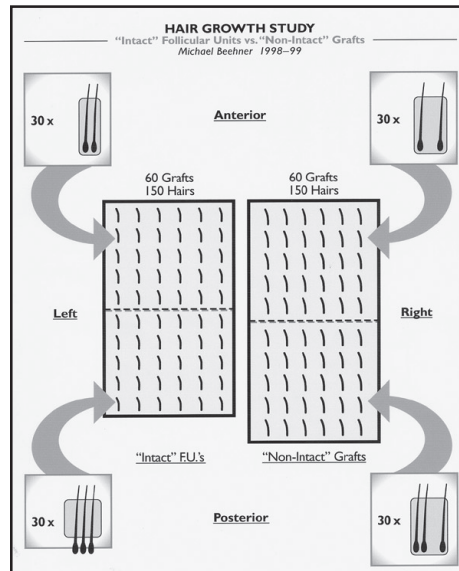


Figure 1. Schematic drawing of graft creation and the study boxes.

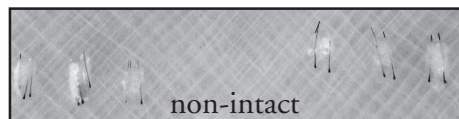


Figure 2. Six "non-intact" grafts from the study.

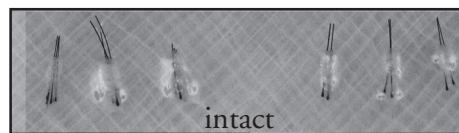


Figure 3. Six "intact" FUs from study.

any telogen stage and "miniaturized" hairs.

A pair of 4mm strips were harvested from the parietal-occipital area. All donor tissue and grafts were kept chilled on ice-saline petri dishes at all times. The grafts were dissected under 10× stereoscopic microscopic vision. The grafts for the first patient (L.C.) were cut by experienced techs. All grafts for the last two patients were cut by the author. The recipient sites for the intact FUs were made with an 18g NoKor needle and those for the slightly larger non-intact grafts were made with a 1.8mm MinDe blade.

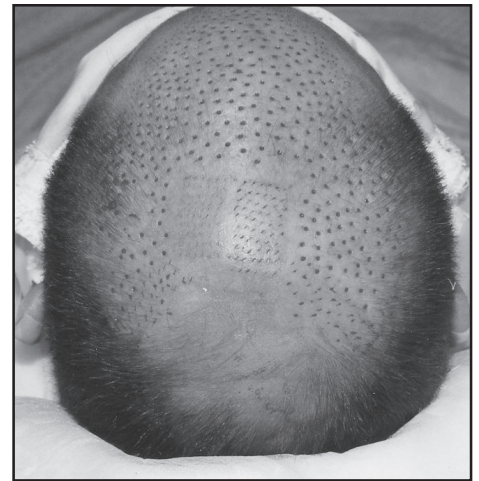


Figure 4. Scalp of Patient C after recipient sites made. Note study boxes in posterior mid-scalp.

All patients were examined at 4 and 6 months, at which time hair counts were done. Two of the three patients were also seen at 9–10 months for hair counts. Patient #2 (J.L.) was a pack-a-day smoker. All three men were healthy and on no meds. None used minoxidil or finasteride.

Results

A total of 450 hairs from each type of graft were placed in the respective boxes. At the 4-month time point, the non-intact hairs showed more hairs growing than the intact ones, 499 hairs to 383 hairs (110.8% vs 88.2%). At the 6-month point, the difference narrowed somewhat, with the non-intact still outgrowing the intact grafts. There was 98.6% growth of the original 450 hairs for the non-intact vs 85.1% for the intact. Figure 5 shows the two boxes at 6 months for Patient C.

Two of the patients were seen at 9 and 10 months, respectively, for follow-up counts. Using just these two patients, there was a statistically insignificant advantage of 86% growth

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Intact vs Non-Intact

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in the non-intact grafts vs. 82.3% for the intact ones. These two patients at the 6-month count were the #1 and #3 in the order of successful growth of hair in both categories. The patient absent at 10 months was in the "middle" of the order of growth percentages, and so his absence would least affect the meaning of the final percentages. The boxes for Patient A are shown in Figure 6.

Discussion and Tentative Conclusions

This study suggests that there does not seem to be any inherent advantage to "intactness" per se regarding hair growth of the follicular unit graft. In fact, the non-intact grafts appeared to have a slightly higher rate of hair growth, at least at the 4- and 6-month marks. At 9–10 months, in the two patients that were studied that far along, the growth in the intact and non-intact areas was statistically the same.

It is interesting that the patient who was a *smoker* had a 70/73% growth in the intact/non-intact boxes at 10 months, compared to 95/99% in the intact/non-intact boxes for the *non-smoker* patient studied to this time point.

It is also fascinating to speculate as to why the non-intact boxes jumped out to such a large advantage early, only to have this advantage return to a statistical "dead heat" near the end of the study. Were there unseen telogen hairs in the intervening tissue of the non-intact grafts that grew during these early months and then, perhaps due to an asynchrony of anagen and telogen cycles, some of these or other hairs receded into telogen or became minia-

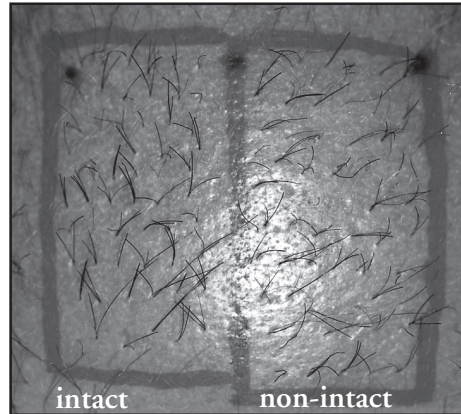


Figure 5. Study boxes of Patient C at 6 months, showing 86% growth of hairs in "intact" box on left, and 90% growth in hairs of "non-intact" grafts in box to right.

turized? It would have helped if these men were followed to 18 months, as Dr. Jennifer Martinick did in her study.

Simply looking at survival of FUs placed under relatively ideal conditions in an area posterior to most of the transplants points again to the fact that the survival of hairs in these grafts is generally not 100% in all patients. At 6 months, these three men in their intact boxes showed 94%, 86%, and 75% growth percentages of hairs, which is all over the chart and very "individual" for each of the three patients. Other than the smoker, who had the 75% growth, what other factors play a role? It is quite encouraging that the non-smoker showed 95% survival of hairs in the intact FU boxes and 99% survival in the non-intact boxes. Because most of our patients are non-smokers (in the United States at least), this would seem to bode well for most of our FU patients.

Obviously, some things have changed since I did this study. Smaller needle holes are used by this author, as well as all other surgeons, and these sites are

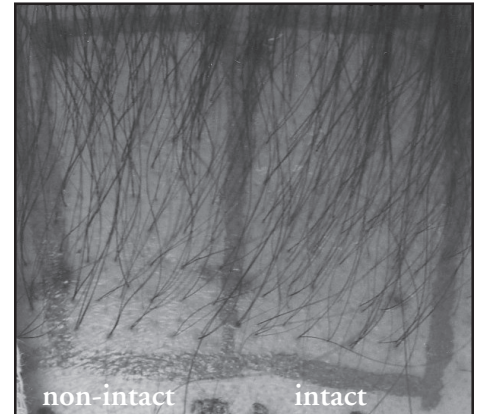


Figure 6. Study boxes of Patient A at 9 months, showing 99% growth in "non-intact" box to the left side of picture and 95% growth in "intact" FU box to the right.

more densely packed together. Whether either of these two factors, the size of the hole and the density of packing, also will be found to impact negatively on hair survival is important for us to find out in the coming years.

Having cut all of the grafts in this study for the last two patients, I can certainly attest to the fact that it is a lot easier to cut around intact FUs than it is to precisely cut through the center of an FU and dissect one hair away from another 1–2 hairs. I certainly don't suggest any advantage to cutting non-intact grafts as I did in this study. However, the excellent growth of the non-intact grafts with their intervening tissue does suggest that perhaps FU grafts should not be too "skeletonized" in our dissecting. Perhaps leaving a little of the surrounding connective tissue may increase the hair yield. This would, however, mean that slightly larger needle holes would be necessary, the density of packing would be less, and more than 1–2 sessions would be necessary to complete a full transplant project. ♦

Notice to ABHRS and IBHRS Applicants

The next ABHRS and IBHRS Board Exams will be held March 13 and 14 in Orlando, Florida. The examination will begin immediately following the Live Surgery Workshop. Those interested in taking the exam should contact the ABHRS office at:

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A Visit to the Office of Dr. Kenichiro Imagawa

Richard C. Shiell, MBBS *Melbourne, Australia*

On Tuesday, August 27, 2003, while on a visit to Japan, I was invited to visit the office of Kenichiro Imagawa, MD, in Yokohama. This is a satellite city of Tokyo and said to be 30 kilometers distant but, in reality, one city blends almost imperceptively with the other. Dr. Imagawa was an early member of the ISHRS and is well known to most of us as one of the Japanese "regulars" at our meetings. He speaks excellent English and is a Past President of the Japanese Society of Hair Restoration Surgery. A Plastic Surgeon by training, he now concentrates almost entirely on follicular unit hair transplantation and has a team of 7 assistants (all RNs) performing two operations per day, 6 days each week.



Dr. Kenichiro Imagawa and staff with Dr. Richard Shiell

mally and finally 0.1% Xylocaine to the deeper tissues to raise the scalp and harden the donor tissues.

New Patients

Many come from Internet inquiry via Dr. Imagawa's Website.

Planning

Dr. Imagawa performs a careful assessment of the donor site for hair diameter and density. He measures with a micrometer and a densitometer at several regions along the donor site to gauge the number of 1-, 2-, and 3-haired groupings that might be obtained from the strip. He says that Japanese hairs vary from 70–90 microns and have a density of approximately 160 hairs per sq cm in the occipital zone and around 120 at the temple area. He usually obtains around 80 FUs per sq cm from occipital donor strips.

Anaesthesia

The patient is placed in a prone position and carefully draped with the hair held clear of the operative field with paper tape. Dr. Imagawa likes to use intravenous midazolam as a pre-medication and dilutes 5mgm of this drug with 5 cc N. saline prior to inject over a 2-minute period.

1% Xylocaine with 1:100,000 epinephrine is injected slowly and superficially via a 30-gauge needle. This is followed by 0.5% Xylocaine intrader-

Removal of Donor Strip

The strip is measured in advance at 1cm in width and marked with gentian violet. Following the method of Thai HT surgeon Damkerng Pathomvanich, he then gently scores the surface with the fine blade and makes his incision deeper by stretching the scalp with skin hooks, and dexterously dissects around the hair follicles. He stays above the galea at all times and encounters only mild bleeding. Very little cautery is required and in his expert hands the strip removal takes only about 15 minutes.

Wound Closure

Because of the relative sparseness of the donor hair and the propensity of Orientals to thick scar formation, Dr. Imagawa likes to close in two layers. He uses 4-0 PBS interrupted sutures every 1.5cm to the deep layer and the same thread (or sometimes 4-0 PDS) continuous for the superficial layer. (It was my impression that in spite of these precautions the scar was a little lumpier than in the average Caucasian patient but certainly better than the usual donor scar in Asian scalps.)

Slivering and Dissection

The strip was pinned to a silicon

rubber surface and the slivering was performed horizontally rather than in the vertical direction seen more commonly elsewhere. Interestingly, the assistant performing this used a head loupe and scalpel rather than the Mantis microscopes and razor blades used by all the other assistants at the Clinic.

The FUs were expertly dissected and placed into individual, color-coded groupings of 1, 2, 3, and 4 hairs. It was amazing to me to see five girls sitting in a row and working intently at their microscopes without one word of conversation passing between them. I have never seen this degree of concentration in Clinics in the West.

Implantation

A further 5mgm of midazolam is given and the recipient site is anaesthetised in the same fashion as the donor site. An iceblock is sometimes found to be useful to minimise discomfort at the frontal injection site.

Dr. Imagawa makes the recipient sites personally with 21- and 18-gauge needles and tailored mini-blades for any two FU grafts. The smaller graft sites are made perpendicular to the hairline and the larger ones placed parallel to the hairline to distinguish between the two as some shrinkage occurs before the assistants complete their implantation.

The assistants, working one on each side, have the FUs in a rectangular graft holder on the left index finger near the implantation site. They have a pair of No. 5 curved forceps in each hand and are as quick as lightning. They hold the slit open with the left forceps and pick up the FU and insert with the right. They seem to each plant one graft about every 6 seconds and once again working without any chatter, the entire 600 grafts were implanted and the scalp checked and cleaned within an hour.

Postoperative Care

The patients require no bandage but

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Parsley Message

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summed up the situation when he said, "When all is said and done, you remember only the friendships. The rivalries and competition dissolve away." Words we all should take to heart. What a moment!

Dr. Bob Haber wrapped up his year as President with a homemade video presentation that had everyone laughing hysterically. He poked good-natured fun at many of the current techniques with the use of photomanipulation and video editing. Has there ever been a President who spoke with more clarity and eloquence? He handed over the Presidency to Dr. Mario Marzola, who now begins his one-year term. We are lucky to have such energetic and talented people, who are not only good leaders but also make the journey fun.

Another highlight was the first meeting of the newly formed Global Council. The presidents of the all the national hair restoration societies were invited to sit together and figure out how to work together to make each society strong and viable. Dr. Mike Beehner and I sat in on the meeting to record the events and make the *Forum* available to help in any way possible, to include posting dates of their meetings if open to outsiders.

Awards were given to the early educators, along with the usual annual awards. This year we had our first Manfred Lucas Award since 2000 and had the first Follicle Awards for the Assistants—long overdue. These will all be covered in the next issue. Receiving an award is extremely gratifying and is

necessary to the field of hair restoration; but we have a number of people in our organization deserving of awards. Some will get them, some will not—and many deserving people may never even be considered. The worth of a doctor or assistant in our field is not validated by an award, but by the number of people whose lives and self-esteem they improved, by what they have given to the field, and by the effort they have put into developing their skills. It is validated by keeping the patient's safety and best interest in their hearts. If one needs to look on the top of a desk or a wall for validation, it will never be found. Here is to those who already have their validation—inside them, where it is most meaningful. ♦

William M. Parsley, MD

Editor Emeritus

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discussion on this hair restoration modality at our meetings and a summary of the Committee's findings may appear in this issue. I think that it is important to abandon the irrational fear of artificial hair implants that has been so prevalent since the fibres were banned in the USA in 1983. In my opinion, the modality needs to be treated objectively and scientifically like any other implantable device.

Stress and Hair Growth

I have heard many tales of stress-related hair problems. These vary from alopecia areata, psoriasis, and canities to localised or generalised acceleration of hair loss. I have never seen any documented proof of this relationship although when one sees microphotography of the dazzling array of nerve fibres surrounding each hair follicle, it certainly makes sense.

Japanese researchers Aoki, Shibasaki, and Kanawa from the Nippon Medical School in Tokyo had an interesting paper on this subject in the August edition of *Experimental Dermatology* (2003;12:371–377). By submitting mice to random electric foot shocks

over a 2-week period they were able to show that telogen was prolonged and the subsequent anagen induction in the hair cycle was delayed. Plasma corticosteroid levels were considerably higher in the stressed group compared with the control animals and the authors suggest that the hair growth cycle in mice may be influenced by the plasma corticosteroid levels.

X-Factor

Dr. O'Tar Norwood and I first proposed this term in our 1984 textbook and it is one of the world's great mysteries, like "Why are we here?" and "Why do the 'Rolling Stones' keep rolling along?"

In my experience, the true incidence is under 1%, but a lot of surgeons may be tempted to attribute the term "X-factor" to any poor result viewed for the first time.

In my opinion, any poor result has to be subjected to a review and a process of elimination to try to arrive at a cause. Have you allowed enough time for full hair growth? Was the recipient area blood supply optimum? Was the graft material first class or of poor quality? Did you have any new and inexperi-

enced assistants helping on the day of operation? Is the patient a scratcher and may have accidentally removed some grafts? Was there a severe post-operative infection? Does the patient suffer from keloid, hypertrophic scarring, or amyloid—all of which may lead to less than optimal results?

In my definition, the diagnosis can ONLY be made after you eliminate those factors (if possible) and then only 12 months after the SECOND operation. If you are strict with yourself and your staff and take extra special care at the second operation, you may then use the term "X-factor" as a possible cause of a repeated poor result.

What is the pathology behind X-factor? Your guess is as good as mine but there are a lot of events in the hair growth cycle that we still do not understand. Thus, although we do not have scientific confirmation for the existence of this condition, please do not discount the possibility that X-factor is real and not just a figment of my imagination. ♦

Richard Shiell, MBBS

Visit to Dr. Imagawa

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are given an elasticised cotton head-band to wear at night to minimize the forehead edema. Oral steroids and antibiotics were given and an appointment made for check-up and suture removal at 7–10 days. Additional operations are suggested at 6–9 months.

Prices

Dr. Imagawa charges US\$5 per graft for an average session with a little more for small sessions.

Results

The resulting growth was very natural and as good as I have seen anywhere in the world. Dr. Imagawa does not favor dense packing of FUs in a single session and encourages his patients to return for further sessions if greater density is desired.

Comments

I was most impressed at the quiet workmanship and professionalism seen at this Clinic, with a large staff working

quietly and harmoniously to produce outstanding results. Oriental hair is not the greatest hair to work with and the majority of Asian surgeons seem to use the Choi and Kim Implanters. It was interesting to see a Japanese surgeon using a relatively standard FU implant technique and achieving wonderful results. He is pretty good at staff relations also and the day after my visit he took his family and the entire staff off to Phuket, Thailand, for a week's holiday. ♦

50 Years Later

continued from front page

Dr. Paul McAndrews, received his award for him.

3. Jay Barnett. Dr. Barnett began his transplanting career as a partner with Dr. Orentreich but quickly started his own practice. His lectures on the early circuits and impressive cosmetic results gave him considerable notoriety, in part due to his use of very small grafts at the hairline and his special technique for suture closure of the donor site.

4. Robert Berger. Dr. Berger was one of Dr. Orentreich's earliest partners. He earned such great respect as a pioneer in hair transplantation that many of the early doctors in our field came to him for treatment. Along with Drs. Pearlstein and Auerbach, he was also known as the clinical "teacher" of many of the leaders in our field.

5. George Farber. Dr. Farber, like our other pioneers, was an early advocate and promoter of hair restoration. He lectured with the early series that Dr. Stough directed in Arkansas and was a major figure in the development of dermatologic surgery. His "open door" policy for surgeons desiring to learn the procedure was instrumental in expanding our field.

6. O'Tar Norwood. Dr. Norwood started transplanting in 1961 and has contributed as much to our field as anyone in history. He wrote the first textbook on hair transplantation,

founded the *Hair Transplant Forum*, and co-founded the ISHRS. And these are just some of the highlights in the career of this remarkable man.

7. Norman Orentreich. Simply put, Dr. Orentreich is "The Father of Modern Hair Restoration." Following his article in 1959, hair restoration began in earnest and nearly all of these pioneers tonight have found their way to his office to learn and share—in fact, probably more transplant doctors have visited his office than any office on earth. In addition to his hair work, he is a leading figure in the development of dermatology and dermatologic surgery.

8. Patrick Rabineau. Dr. Rabineau began transplanting in 1963 after visiting Dr. Orentreich and, along with Dr. Arouet, was a leader in bringing hair restoration to Europe. He is a past president of both the French Society of Dermatologic Surgery and the French College of Scalp Surgery. Additionally, Dr. Rabineau is a prolific writer and lecturer.

9. Richard Shiell. Dr. Shiell started transplanting in 1967 and has been a prolific and enthusiastic lecturer and writer. He co-authored Dr. Norwood's second textbook and was *Forum* Editor from 1995-98 along with his numerous other credentials. His energy and love of the field has inspired many to contribute and be their best. Dr. Shiell has always been "center stage" in every

significant development and is one of the most beloved figures in our field.

10. Bluford Stough. Dr. Stough started hair transplanting in 1961 and immediately embraced and advanced our field. No one pushed education and exchange in our field more than Dr. Stough through his series of meetings in Hot Springs, Arkansas. As one of the founders of the American Society of Hair Restoration and the American Society for Dermatologic Surgery, he is truly a great pioneer in hair restoration—and... the father of Dr. Dow Stough.

11. Hiram Sturm. Dr. Sturm assisted Dr. Orentreich in his landmark studies that lead to the development of hair transplantation. He started transplanting in the early 50s even before the article was published. He has been a major figure in the development of dermatologic surgery in general and dermabrasion in particular, while also being a leader in many dermatologic societies.

12. Walter Unger. Dr. Unger was not only an early educator in the field of hair restoration, but he has left his footprints everywhere. He has written 3 editions of his textbook *Hair Transplantation* and his 4th edition, co-authored with Dr. Ron Shapiro, is presently at press. His constant vigilance in asking for proper scientific studies has been instrumental in giving us valid data. He is truly one of the giants in our field. ♦

Notes for a Prospective Hair Restoration Surgeon

Dear Harry,

Thank you for your phone call yesterday. I am sorry if I did not seem to share your undoubted enthusiasm for a career in hair transplant surgery but there is a great deal more to this business than learning how to plant hair follicles. As promised, I have jotted down a few points for you in relation to your quest.

Unlike some other branches of surgery, it is not difficult to learn the basic techniques in hair restoration. The anatomy is simple and there are only a small number of surgical procedures. Furthermore, you are operating predominantly on young, healthy patients so post-operative problems are rare. You do not need surgical Boards, although many hair surgeons have come from one of the recognised Specialties. If you intend to become serious in this field, I recommend that you read the recommended HT literature and take the Certificate of Added Qualification in Hair Restoration offered by the American Board of Hair Restoration Surgery (ABHRS). There are numerous training courses conducted each year in the USA as well as in some other countries. These are costly but are a good value as you meet other enthusiastic practitioners and obtain some “hands-on” tuition. After a few years, and when you have gained more practical experience, you may eventually take the Board Certificate in this specialty.

Along with many other HT surgeons, I permit visitors to my surgery for short periods without charge. You are free to observe whatever is going on but I cannot promise to have a full range of baldness variants or operative procedures while you are in attendance. The days can be very long and boring for students as my nurse and I work under considerable pressure for 10 hours each operating day. You would get some hands-on experience with dissection and planting, however, and opportunity to ask questions.

There are several excellent books on Hair Replacement Surgery, which I shall list at the end of this letter, but the best way to keep up to date is by reading the informative bi-monthly magazine *Hair Transplant Forum International*. This is the official newsletter of the ISHRS, which is only sent to members of the Society (included in membership dues).

Hair Transplant surgeons are mostly a pretty friendly lot, and once you have a little knowledge and experience and have joined the ISHRS, you are welcome to visit and observe almost anyone in the world.

As I noted earlier, learning the technique is not the difficult part. Getting enough patients in order to maintain and improve your skills is the main problem.

Once you have opened your practice, your problems are only beginning as you need to advertise widely and consistently to maintain patient inquiry. Yellow Pages, newspaper, TV, and Internet advertising are all highly competitive, and many patients who do find you are “shopping around” for the best price. Of the patients who come to you as a result of advertising, only about 10% will proceed with surgery, but you may expect that this person, if satisfied, will have at least 1–2 further hair restoration procedures with you over the next few years.

In recent years, no Hair Transplanter has survived long without buying an existing HT practice or by purchasing a franchise offered by one of the bigger hair restoration chains. If you decide to make it on your own, you would be wise to continue in your existing work until the volume of transplant business builds up to a self-sustaining point. This can take many years depending on how much favourable publicity you can continue to attract.

Many prospective HT surgeons have been influenced by rash and optimistic promises from friendly hairdressers and fellow doctors. “*I can send you loads of balding patients*” is the claim and when these fail to materialise in sufficient numbers, the doctor has to either spend a great deal on paid advertising or watch his or her business collapse.

Your aims may be far more modest of course and you might only be wishing to improve your lifestyle by supplementing your income with one or two transplant sessions a month. This is certainly possible *in theory* and was the way that most of the present transplanters got started in years past.

Two things have changed. Firstly the techniques are now entirely different. Instead of a 1-hour operation involving the transfer of 50 scalp plugs of some 20 hairs each, we now implant some thousand or more “follicular units” in an average procedure. This takes 4–6 hours and you require 2–4 assistants for the tedious dissection and implantation or it will take even longer. Unless you are doing regular work, it is difficult to get the team running smoothly.

The next difficulty is that, unlike the pioneer days of 25 years ago when there was work for all, you now have expert opposition who will resent a newcomer to the field. They will lose no opportunity to remind patients who are “shopping around” that you are a beginner. Your lack of confidence and lack of a portfolio of “before and

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after” photographs will become obvious to many patients when they consult you. Worse still, for a couple of years your surgical results may fall well behind the standards of other transplanters in your area.

As with all other branches of surgery, I think the day of the “dabbler,” the occasional cosmetic surgeon, has passed. It is mostly a serious, full-time business now. For this reason, I foresee transplanters of the future being those doctors who are already established in cosmetic surgery and who have added hair work to their list of procedures. Once you are in cosmetic practice, you have an established credibility and you have the staff and facilities. It is just a matter of picking up the additional techniques, getting experience, and maintaining your skills. This too is not easy as many existing staff members do not like the tedious dissection and implantation of follicular units, and you may need to employ additional part-time assistants who feel comfortable with this technique.

So in summary Harry, it is not going to be easy for you. As you are currently a busy G.P., you really only have one realistic path in my opinion. That would be to buy an existing practice or franchise when one becomes available. This will provide you with one or two days of surgery per week but may commit you to move to wherever that practice is located.

While you can certainly learn the techniques, your chance of success is statistically very low unless you have the stomach and money for very extensive and prolonged commercial promotion of your practice. For a young plastic surgeon or cosmetic dermatologist it will also be hard, but these costs may be absorbed into his or her existing practice and his or her present nurses can perhaps be given specialised training in hair work to make his life easier.

I am sorry if I sound a bit pessimistic but I have seen a great many doctors enter the hair transplant field over the past 20 years. Only about 10% have lasted the distance, and it has become a lot more difficult in the recent years with the new techniques and increasing competition and commercialisation.

Please let me know if I can be of further assistance.

Yours sincerely,

Richard C. Shiell, MBBS *Melbourne, Australia*

Modern textbooks on hair replacement surgery:

1. Unger WP. “Hair Transplantation- 4th Edition” (Marcel Dekker, New York, NY; 2003).
2. James Harris and Emanuel Marritt (Square One Publishers, New York; 2003).
3. Stough DB and Haber R. “Hair Replacement, Surgical and Medical” (Mosby, 1995).

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New Cost-Effective, Ergonomic Way to Magnify Donor Hair during Follicular Unit Graft Dissection: LCD Monitor with Video Magnification

Sharon A. Keene, MD *Tucson, Arizona*; Gary H. Gibson, B.ME *Phoenix, Arizona*

It has been established in the hair restoration literature that the use of magnification during follicular unit graft dissection results in less transection and greater graft yield. The cost of the tools for magnification, and the reluctance of surgical technicians to learn to use them, has prevented some clinics from utilizing these tools despite the known benefits of magnification.

There are several types of magnification currently in use, offering various powers of magnification and varying price ranges. In general, higher magnification translates into higher equipment costs. The lower cost equipment, such as loop magnification, offers a range of magnification from 2×–3.5×—and as the magnification increases the vision, the work area decreases. Loupes cost about \$85. Binocular Magnifiers cost around \$225. In addition to being relatively low cost, loupes may be the easiest form of magnification for a novice technician to learn to use. That is because they are able to maintain all the normal visual cues of looking directly at their hands while manipulating the tissue, in order to process information to coordinate the eye-hand movement. In contrast, microscopes offer higher cost, higher magnification, and lower rates of transection, which has established this tool as the superior method of magnification over loupes and backlighting. The most popular microscopes used for dissection today are the Meiji Stereo Microscope, which has a magnification of 10–20× and costs \$800–865; and the Mantis Microscope, which offers a magnification of 6–10× and costs between \$1,800–2,650 depending on accessories. Video Microscopes such as those used by pathologists offer a range of magnification from 10–50× and range

in price from a few thousand to over \$10,000.

In addition to the expense involved with microscopic magnification, there are several other more practical disadvantages. There is a definite learning curve for technicians to learn to use it for dissection, and this can be discouraging to those who feel more adept with either no magnification or with lower powers of magnification that allow them to look directly at the

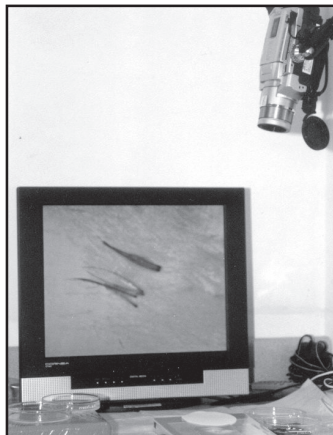


Photo of grafts viewed on LCD screen using video magnification

tissue. There is a significant ergonomic issue with using available microscopes. While the Mantis microscope allows users to sit upright, unlike the stereomicroscope where the user must be hunched over, there are still major ergonomic constraints due to the fact that the head must be perfectly situated in order to see the magnified field. Even small movements of the head and neck can cause the user to lose sight of the subject being magnified. Therefore, for the duration of the time the assistant is dissecting, they must hold their heads erect, and virtually immobile. Over the course of an hour or more, this can cause user fatigue and stiffness.

For almost a year now we have been

using a new method of magnification, an LCD monitor and video camera. This method offers greater ergonomics and ease of use, with the unique advantages of oversight over graft cutting technique and quality as well as ease of teaching new assistants. We have been using a *JVC camera with 16× optical zoom capability* mounted 22.5 inches above the working surface, attached with an S video cable to a 17 inch Cornea LCD monitor, to achieve an 11× magnification, with essentially no limitations on working distance or head and neck range or motion. We find the resolution of the viewing screen to be slightly less than the Mantis microscope, but more than sufficient for routine graft dissection. The fact that there is no lens for the user to peer through, and the presence of a large viewing screen, means that both user and any observer are able to view the graft dissection. Surgical assistants no longer need to maintain the same immobile posture required by microscopic magnifiers. Furthermore, the surgeon is able to see precisely what the technicians are doing and seeing. Quality assurance and teaching become easily accomplished tasks in contrast to the microscope where only the user can see the subject of magnification. The cost of the video magnification system is extremely competitive, offering the same high level of magnification as the Mantis, at a cost of around \$1,200 including accessories.

The disadvantages to date are that we have not been able to find a camera setting on our video camera that allows the concomitant use of backlighting. Furthermore, it is necessary to have some technical knowledge in order to adjust the camera lens, to prevent

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Journal Review



The Influence of Finasteride on the Development of Prostate Cancer *New England Journal of Medicine*, July 17, 2003, Vol. 349 No.3

John D.N. Gillespie, MD *Calgary, Alberta, Canada*

As we are aware, finasteride reduces the level of dihydrotestosterone in the hair follicle and in the prostate. It is an important advancement in the medical treatment of male pattern hair loss and an important adjunct to hair transplant surgery. Many surgeons' initial fears that finasteride would compete with surgery, are now abated. I offer it to most of my patients. Those of us who are prescribing it regularly need to be aware of its effects and side effects.

The authors did a study of over 18,000 men, 55 years and older. Each had a normal rectal exam and a normal PSA level, were randomly assigned to 5mg of finasteride or placebo, and were studied for 7 years. Biopsies of the prostate were done if at their annual review there was an abnormal rectal exam or if their PSA level exceeded 4.0 ng per millimeter. Those on finasteride had their PSA result doubled before being reported to the investigator; therefore, an actual reading of 2ng would be sufficient to warrant a recommendation to biopsy. All men who had not yet been diagnosed with

prostate cancer were offered an end of study biopsy.

Over 9,000 men were included in the final analysis. 803 of the 4,368 men in the finasteride group (18.4%) and 1,147 of the 4,692 (24.4%) men in the placebo group developed prostate cancer. The finasteride group had a 24.8% reduction in prevalence over the 7 years of the study. High-grade tumors (Gleason scores 7–10) were, however, more common in the finasteride group. 6.4% of the 4,368 men in the finasteride group and 5.1% of the 4,692 men in the placebo group developed high-grade tumors.

Sexual side effects were more common in the finasteride group. Urinary symptoms were more common in the placebo group.

What does this study mean to our patients? I spoke with the lead investigator, Dr. Ian Thompson of San Antonio, and asked him this question.

He feels that much media interest has focused more on the increase in high-grade tumors versus the definite reduction in overall prostate cancer

incidence. (6% of the men in the finasteride group were spared from prostate cancer. Only 1.4% more developed a high-grade tumor.)

Because the finasteride group had 25% smaller prostates, proportionally more gland was sampled at biopsy, possibly biasing *against* the benefits of finasteride.

On the issue of higher-grade tumors, Dr. Thompson feels this may be an artifact. It is possible that the finasteride itself causes a histological change that mimics high-grade disease. This happens with androgen-deprivation therapy. He personally is uncertain whether the effects of finasteride on tumor grade will ever be known because there are many biases.

The bottom line: In this study, finasteride reduced the incidence of prostate cancer by at least 25% but *may* have resulted in a few higher-grade tumors.

I think this is very positive; what do you think? ♦

“A new idea is delicate. It can be killed by a sneer or a yawn; it can be stabbed to death by a joke or worried to death by a frown on the right person's brow.”
~Charles Brower

Video Magnification

continued from page 470

strobbing during focusing; as well as to achieve the direct hook-up from camera to monitor.

Recently we have begun to experiment with another camera that does not have the capability of videotaping,

but that can be attached to the video monitor. Our goal was to find a camera that was cost competitive, and that would maintain the same magnification and ergonomic advantages achieved with the video camera

without adding additional expense. We have identified such a camera, and have found it to be compatible with backlighting. ♦



Once Upon a Time...

"There were even two papers on the theme of 'How to make a do-it-yourself extender for nine bucks.' Patrick Frechet was chairing the session and we could tell that he was definitely not amused!!"

—Richard Shiell, MBBS, reporting on the 2nd ISHRS Annual Meeting in Toronto, Canada
(Vol. 4, No. 5, p. 8; September/October 1994)

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"It is a large operation and lots of pain. But, this is only our opinion. When you do scalp reductions in the German-speaking countries, you will not have any competition—because no one is doing them. We are very happy with our small grafts."

—Claudia Moser Prawetz Vienna, Austria (Vol. 3, No. 6, p. 15; November/December 1993)

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"How many micrografts are needed? The number will vary of course, depending on hair color, texture, healing, etc... but in most cases, more than you originally thought! A practical endpoint is always whatever number of micrografts ultimately stops an observer from staring at the hairline."

—Manny Marritt, MD (Vol. 1, No. 3, p. 2; January 1991)

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HAPPENINGS CONT....

with help from a vascular surgeon. Dr.

Alex Ginzburg showed his w-plasty technique in repairing widened donor scars. Dr. Melike Kuelahci discussed an in vitro study on follicular units staining them with Trypan Blue and examining them under the microscope. Using a digital imaging analysis system she concluded that dessication is more damaging than trauma and "chubby" grafts were more resistant to damage.

The next session of the day was the complications panel during which a new concept was used where cases were re-enacted by Drs. Mario Marzola and Jim Vogel with volunteers acting out various true-life scenarios. The types of cases presented and discussed included a patient requiring repair work for punch grafts, low density and poor coverage after transplantation, unsatisfactory donor scars, young patients, and post transplant effluvium. This was a thought-provoking session showing examples that we all commonly come across and an excellent exercise for the not so experienced in the audience.

The general session ended with a most memorable introduction to some of the outstanding pioneers in hair

surgery. Among those honored were names that most of us have only read about in articles and text books: Dr. Blu Stough began transplanting in 1961 and orchestrated the first meeting devoted to hair transplant surgery in 1973 in Hot Springs. Dr. Richard Shiell, who started in 1967, and Dr. Walter Unger have been major influences within the ISHRS since its inception. Dr. Sam Ayres III, who was absent, also began in 1961, and early on in his career used small 1.0mm punches. Dr. O'Tar Norwood started in 1961 and wrote the first textbook on hair transplantation in 1973. Jay Barnett was the first to do larger sessions (150 grafts), suture donor sites, use smaller 1.0mm grafts, and use steroids to reduce swelling. Dr. Robert Berger, an early partner of Dr. Orentreich, began transplantation in the early 1960s. Dr. Hiram Sturm began in 1952 and worked with Dr. Orentreich on his original study. Dr. George Farber started in 1963 and along with Dr. Sturm is considered a major figure in dermatological surgery. Dr. Patrick Rabineau from France studied transplants with Dr. Orentreich back in 1963. Dr. Tom Alt began in 1973 and was the first to present a talk on scalp reduction surgery for male pattern baldness. Last, but by no means least, was the father of hair transplan-

tion, Dr. Norman Orentreich, who first began hair transplantation in 1952 and published his first article on the subject in 1959. He is also a founder and first President of the American Society for Dermatologic Surgery (ASDS).

Finally, we had the opportunity to see live examples of work from various practitioners. Dr. Shelly Kabaker's hairline advancement surgery as presented in his lecture was superbly illustrated in his patient. Dr. Jeffrey Epstein had a patient who had received large numbers of grafts to his chest. Dr. Ron Shapiro showed 3 patients demonstrating his usual flawless work. Dr. David Seager had 2 outstanding examples of his surgery. Dr. Patrick Frechet's patient had excellent results after extension and triple flap rotation. There were other impressive examples of surgery by the likes of Drs. Walter Unger, Mike Beehner, and Carlos Puig. Dr. Gary Hitzig had a patient who had undergone surgery using his "auto-cloning beard hair" technique. There were two patients who had received artificial hair implantation, one each of Dr. Richard Shiell and Dr. Gerry Brady. Dr. Shiell's patient, George, is now a regular attendee at the Live Patient Viewing portion at conferences and is still happy with his artificial hairs after several years.



SATURDAY, OCTOBER 18, 2003 • JEFFREY EPSTEIN, MD MIAMI, FLORIDA

Too bad I didn't start my day with any of the karma provided later by Joe Greco—but more on that later. The morning workshops were consistently outstanding, thanks to the expertise and the ability to express such expertise on the part of the workshop presenters. As workshop director, I was afforded the luxury of bouncing around the different workshops, each of which was more valuable than the next. Drs. Parsley's and Jimenez-Acosta's presentation of the microscopic world of hair transplantation, Drs. Rose's, Nusbaum's, and Washenik's review of the differential diagnoses of hair loss, and Drs. Cotterill's, Eisenberg's, and Kingsley's workshop on female hair loss were well

worth waking up early for. Unfortunately I did not have the opportunity to listen in on the workshop on artificial hair, but several attendees told me it was very informative.

The morning's general session opened with Dr. Matt Leavitt's presentation of the material covered in an article that appeared earlier this year in the *Forum* on the various hair loss "remedies." This extensive amount of material was succinctly summed up. The supply source for most of these products is the Internet and direct sales, which for most patients is much more convenient than visiting a doctor's office for purchasing, opening the door for savvy marketers to sell these unproven

products. The first group, the minoxidil-based products, include Avacor, Hair Advantage, Xandrox, and Folliguard. These are considerably expensive, and most contain unknown concentrations of minoxidil—Xandrox contains 12% minoxidil. The group of herbal products include NuHair, Hair Genesis, and others, some of which contain rosemary, others saw palmetto. Note that saw palmetto does not exert its effects on the prostate by blocking DHT, therefore is unlikely to be of benefit for the treatment of MPB. Other products include Nizoral shampoo (anti-androgen modulation demonstrated in one study), dutasteride

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HAPPENINGS CONT....

(phase III studies needed), fluridil

(topical anti-androgen that, despite the lack of any conclusive results shown in studies, holds significant promise), and finally the Laser Comb (definitely intriguing but further objective studies are needed).

The next part of the session was the 6- to 8-month follow-up on several studies conducted at the 9th Annual Live Surgery Workshop in Orlando. Dr. Alex Ginzburg presented the 6-month results of follicular unit survival after 24 hours outside of the body. Among 20 follicular unit grafts stored in saline solution at 4°C for 24 hours before being transplanted into the scalp, only 6 grew hairs; this was compared to 19 out of 20 follicular unit grafts transplanted immediately that were growing at 6 months. In the discussion that followed, the results from Dr. Jimenez-Acosta's poster presentation were given, in which it was shown that the rate of growth of grafts that were frozen is even lower than the cooled grafts in Dr. Ginzburg's study. Dr. Jerzy Kolasinski presented his study "Clinical Evaluation of Transplant Debris Tissue During Hair Transplant Surgery". The absence of any hair growth from non-hair bearing donor tissue refutes the possibility of hair growth from discarded tissue. Dr. Melvin Mayer then presented "Graft Density Production Curve with Dense Packing," which found that the rate of hair growth was 95%, 76%, 70%, and 82% in follicular unit grafts transplanted to a density of 20, 30, 40, and 50 per cm², respectively. These results, surprising given the overall relatively low rate of growth as well as the phenomenon of the higher growth rate in the most densely packed region, require validation with additional patient studies. Finally, Dr. Michael Beehner presented his "Study of Synchronization and Unsynchronization of Hair Growth Over Time." The rate of

growth of hairs transplanted 7 months earlier was 90%, and in the near future the hairs will be followed to see if hair growth cycles are all synchronized.

These results should be very interesting.

Dr. Beehner also presented his study "The Artistry of Creating the 'Mirror Image' Laterally in Hair Transplantation." This perceptive study demonstrated the importance of achieving balance between the transplanted region on the top of the head with the side temporal/parietal areas. Also presented in this lecture was a novel technique for elevating laterally the flat hairline to improve aesthetics. Essentially this involves removing flap or transplanted scalp along the leading edge of the hairline, thus creating a more receded look—truly very interesting, and certainly reflecting thinking outside of the box, for most surgeons approach this problem with doing elliptical scalp reductions from behind the hairline. One of the more novel lectures was given by Joe Greco "Putting the Zen into your Hairline by Transferring to the Right Brain Mode." During his presentation, Joe was able to have at least this attendee "feel" the creative, calm right brain mode, which allows one to focus on the eyes in the mathematical symmetry of the face. Dr. Jennifer Martinick's presentation "Angle, Orientation, Direction (AOD): Micro-Attention to Detail" demonstrated the importance of approaching the hair transplant procedure in 3-D. In this light, the potential advantage of coronal graft placement was discussed analytically.

Several presentations were given on office safety. Featured speaker Justin Kuralt of the company Total Medical Compliance summarized the key components of HIPAA regulations. I, Dr. Epstein, explained the situation of office accreditation in Florida, and the importance of accreditation in terms of patient safety and physician protection. Finally, Dr. Edwin Suddleson presented the results of the survey conducted over

the preceding 2 days of ISHRS members on emergency preparedness. Our organization's members for the most part are basically prepared for patient safety, but exceptions do exist, and the danger of these exceptions was discussed.

The final part of the general session on Saturday was a potpourri of items. Dr. Vincenzo Gambino of Italy presented 4 cases in which hair restoration played a major role in healing the damaged psyche of a patient. Dr. Paul Straub discussed his current technique of donor site closure, involving a deep 3-0 Maxon placed midway between the bulb and skin suture, followed by a fine Prolene cutaneous suture. He claims that the consistently fine lines achieved with this technique neutralize the primary promoted advantage of FUE. Dr. Robert True lectured on a new non-amide, non-ester injectable anesthetic. Articaine (Septicaine®), while of a slightly shorter duration than lidocaine, does not have the carcinogenic risk that has been shown with lidocaine. Dr. Fabio Rinaldi of Italy showed the beautiful results achieved with FUG transplanting in women. In his hands, often a single procedure of as many as 3,000 FUs is all that is required for optimum aesthetics. A video presentation from Dr. Hoellmueller of the Moser Clinic of Austria demonstrated the "spatula" dissection technique. By pressing down on the initially dissected FU graft, an additional amount of surrounding skin can be removed, creating essentially the ultimate "skinny" graft, which I think is more appropriately called an "anorexic" graft, the absolute opposite of the "chubby" graft. Finally, I presented the results of a study I conducted on donor site closure technique. My hypothesis, that a more superficially placed simple running 3-0 Prolene suture produces a narrower donor site scar than the same suture with deeper bites into the mid-subcutaneous fat, was confirmed clinically, but not statistically.

See you next year in Vancouver.



SUNDAY, OCTOBER 19, 2003 • COLIN WESTWOOD, MD CHESHIRE, UNITED KINGDOM

The day began with "Breakfast with Champions." Attendees could move round various tables at which "experts" were sitting. It was an opportunity for individuals to ask questions in an informal setting. A number of experts were present including Drs. Paul Rose (hair cloning) and David Seager (dense follicular packing). Most people found the session useful and it would be worth repeating at future meetings.

In the following general session on the last day, slightly different areas were covered. Dr. Samir Ibrahim discussed moustache repair. He pointed out that the moustache is very important to a significant number of people in the Muslim community. In India the moustache is a symbol of wealth. Even in the West, certain individuals, for example, Charlie Chaplin, Adolf Hitler, and Salvador Dali are characterized by specific moustaches. Dr. Ibrahim treats many people with abnormalities such as cleft lip as well as those who have a constitutionally poor moustache. He used to graft moustache areas with about 350 follicular units; he now finds 500 follicular units give a fuller result.

On a similar theme, Dr. Mohammad Mohmand (speaking on behalf of Dr. Asad Toor) gave a talk on follicular unit extraction (FUE) in South Asians. Many Asians go on pilgrimage every year. Because the head is shaved closely, any scalp scars become very prominent. Dr. Mohmand has used FUE as a method of scarless scar revision. He feels that it is the method of choice in moustache repair of cleft lip in these patients.

Increasingly doctors from Brazil are leading the field in hair restoration. Drs. Carlos Uebel, Arthur Tykocinski, and Marcelo Gandelman are household names. Dr. Antonio Ruston carries on the tradition. He gave a beautiful demonstration with the aid of computer graphics, of the importance of the angle at which a graft is placed. At 90° the hair was thin and "see through." As the angle was decreased to 60°, 45°, and finally 30° the hairs shingled over each other and the appearance was thicker.

Dr. Shagufta Khan has worked with dyes as a method of highlighting the hair follicle and easing the dissection of the hair of grey haired people. She initially experimented with a dark background and then tried impregnating the donor area with charcoal. To do this, she wrapped a warm charcoal-laden cloth over the donor area before removing the strip. She now finds that the dye methylene blue is very useful. The donor strip is placed in a solution of methylene blue for 15 minutes. Dissection of the follicles is facilitated. The slightly blue tinge of the grafted hair fades within a few days.

As usual the final session, "Open Microphone Forum" was the most useful part of the whole meeting. A question was asked about "pitting." Dr. Bernard Nusbaum felt that certain patients with high sebaceous activity are particularly prone to pitting. He pointed out the importance of a slight protrusion of the graft during placement.

The place of Dutasteride was questioned. On a show of hands, a significant number of doctors have used the drug in spite of the fact that, as Dr. Epstein pointed out, it is "off label." Dr. Epstein mentioned that it is an effective blocker of Dihydrotestosterone 1 and 2, causes a rise in serum testosterone, and has a very long half-life.

The question of "skinny versus chubby" arose. Studies have shown a 7–15% increase in growth of chubby grafts, but it is not certain if this growth is

permanent. Dr. Bill Parsley cautioned against "chasing the telogen follicles." He felt that there could be diminishing returns as increasing amounts of bald skin were transplanted.

The session ended with a fascinating discussion of finasteride and transplanting the very young patient. Dr. Martin Unger admitted transplanting two 16 year olds who were suicidal over their hair loss and were being managed by psychiatrists. He also had transplanted another very young man who was threatening suicide and who indeed did commit suicide after the transplant. He said he would have felt responsible if he had not agreed to perform the transplant. Dr. John Gillespie emphasized the importance of finasteride. He said he likes to tell these patients that medical treatment is an emergency but surgical treatment is elective. Dr. Vance Elliott echoes this sentiment emphasizing the importance of playing for time and hoping the patient develops a maturity.

It was then left to Dr. Marc Avram to end the session with the importance of giving the patient time. He said that we must give adequate time so that the young person understands why we are advising against surgery at the present.

As the meeting finished at lunch time, a small number of attendees prepared to take the IBHRS annual examination. It was a full meeting, a tiring meeting, but probably good preparation.

I wish them well. ♦

Fresh air and fresh ideas in Hair Restoration

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A Patient's Light-Hearted Commentary on His Decision to Have a Hair Transplant and the Experience Itself

Dr. Gillespie:

These are the memories of my transplant procedure, and as I have nothing else to do but relax for a few days, I thought I'd write them down.

I have had information from your office for over 2 years and it has taken me that long to even make the phone call to find out more about it.

Permanently changing one's appearance, even when it's for the best, takes an awful lot of thought and consideration. How good is this guy? What will I look like? What if it doesn't turn out right? Do I even have the guts to go through with it?

Everyone has heard about and seen bad plastic surgery and hair transplants and I did not want to be one of those casualties. For me it was a "Major Decision." So it takes me over two years to get enough nerve to even make the phone call because I'm not sure I can do it... but my hair is going fast and soon it will be too obvious and too late if I don't do something. So I phoned and talked to Kathryn... she was very pleasant, which put me at ease, she explained everything and answered all the questions I had including prices. She didn't rush me or push me for an appointment, which I really appreciated considering how much of her time I took.

Two days later I called back for a consultation appointment... after all there's no cost and I can find out more about it... and, I'm hoping I can get away with the cheaper 700 follicle job... 700 hairs should do a lot, I'm not completely bald. I'm a little anxious when I get to the Clinic to say the least, but the nice easy un-doctor-like waiting room puts me at ease... then Dr. John Gillespie appears... quickly... check out his hair, I know he's had it done. Not bad, I'm tempted to ask who did it. A nice casual conversation about the procedure and then the bad news... I

need the big one, the 1,400–1,500 job, guess I didn't realize how bad off I was. Double the hairs and double the price... there goes my transplant and soon the rest of my hair. I tell my lovely wife the bad news and she says how about if I give you that for your 60th birthday, you're worth it, she says... what a sweetheart. Yeah... she's right again... I'm worth it!!! Alright!!! I've got the OK... but do I have the nerve, it's still a major decision.

Two weeks later, I can hardly believe I'm booking an appointment. June 2... a little nervous but confident... it's a Monday, they will all be fresh after the weekend and will do a great job... YES... Monday is a good day. I call the Clinic on the way in... Marcy answers and I tell her I would like to cancel today and re-book for next Monday... silence... I quickly tell her I'm just kidding... no use getting anyone upset that may be working on me... it's just a joke, I'm already on my way.

Arrived a little early... perfect... no one will be rushed. Dawn gives me pre-op instructions and prep... Dr. G. arrives and has a look at me to determine the hair line etc... yes, he looks refreshed... Monday is a good day... but why is he wearing those big glasses? Down the hall and into "The Room"... the operating room, introduction to the assistants and then face down on the doughnut... and now the painful part, Dr. G. says... he's kidding right? Ha... just a little price... I knew he was kidding... thank goodness. Cut, cut, snip, clamp... what's that noise?... it sounds like he's ripping a strip of Velcro off the back of my neck... WOW... this is going to hurt later I just know it is. Cut, snip... "Oops," he says... he's kidding... right? "The Guess Who"... that really takes you back doesn't it... huh... he knows all the words... must be from his hippy days... not a bad singer actually... but should he be singing

while he's ripping a strip of my scalp off?... concentrate!!! Five months before I can wear a motorcycle helmet again... this guy's funny... he's kidding again... right? Dawn told me he would say something like that... just doesn't like bikes... guess he never rode a Harley.

OK, the back is done, just a little prick in the forehead now. Little prick... my head is starting to feel like a pin cushion... how come so many needles?...

WOW, you got to be kidding... you bent that needle pushing it through my scalp?... Oh... this is really going to hurt later. OK, now the holes for planting... all 1400... I can hear it but I can't feel it, thank goodness. Holes done, Dr.'s gone, better check the girls out, cutting up my scalp... WOW... what a thick piece of skin... I don't want to see any more. Salmon sandwich for lunch... good choice, haven't had that in a long time... I wonder if it's free range or farmed... probably free range, it's from that healthy little store... sure, it's probably free range. Planting time... I wonder how many girls are working on me... I know there is one on each side and I'm thinking there's at least one at the back some of the time... hard to tell... hope they had a good weekend... this is important stuff. All done, squirt, squirt, wipe, wipe... down the hall to get changed... where's the mirror?... WHERE IS THAT MIRROR?... WOW... I look like a pin cushion, this is really going to hurt when it thaws out... but it looks good already ... Hey!!! I got hair... MONDAY IS A GOOD DAY!✧

Bill Greig
Calgary, Alberta Canada

Beard and Moustache Hair Transplants

Bradley R. Wolf, MD, ABHRS Cincinnati, Ohio

Case Report

- 47-year-old high school art teacher
- Chemical burn by battery acid in moustache, peri-oral areas
- All grafts placed by author
- All one-hair grafts in upper lip, lower lip, medial buccal areas
- All incisions made perpendicular with 15 and 22.5° sharp point scalpel
- Local anesthesia with epinephrine
- 13 surgeries performed over 6-year period
- Maximum 350, minimum 26; average 153 grafts per surgery
- Total grafts= 1,983

Patients may present to physicians requesting increased follicular density in the beard, moustache, and/or peri-oral areas. This request can be due to a variety of conditions including:

1. Trauma/Burn
2. Congenital absence of hair
3. Cleft lip
4. Dermatopathology (Scarring alopecia)
5. Folliculitis

The following must be taken into consideration:

Trauma/Burn. The depth of the existing skin must be adequate to make an incision deep enough to accept the length of the graft without damaging underlying structures. If the skin is too thin, tissue expansion may be considered to remove the scarred area. If there is any question, inconspicuous test incisions can be made to evaluate depth of the tissue.

Congenital absence. By history, it is important to rule out scarring alopecia, and be assured that the lack of facial hair has in fact been present and stable since birth or since puberty.

Cleft lip. Often multiple surgical procedures have been performed to correct a cleft lip. This can thin the tissue to unacceptable depths too thin

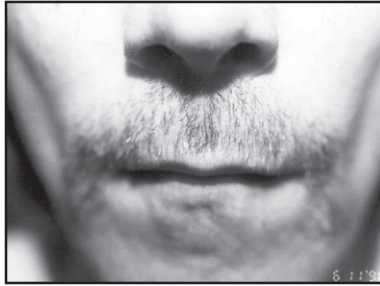


Figure 1. Before grafts

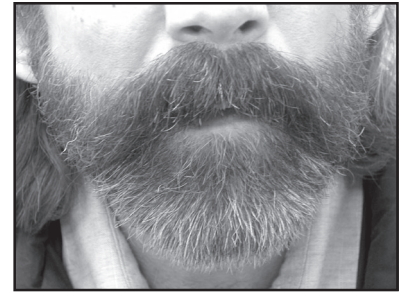


Figure 2. After 1,983 grafts

to be able to make an incision deep enough to accept the dissected follicle. If there is any question, inconspicuous test incisions can be made to evaluate depth of the tissue.

Dermatopathology (Inflammatory or Scarring Alopecia). Any area of alopecia containing active inflammation is an absolute contraindication to hair transplantation. Alopecia areata commonly occurs in the eyebrows and can occur in a patchy distribution in the beard, moustache, and/or peri-oral areas. This can be associated with concomitant areas of loss in the scalp or other areas of the body. A biopsy is indicated if there is a suspicious history or lesion suggesting active inflammation or scarring alopecia. In scarring alopecia, the classic appearance of lack of epidermal surface structures should cause suspicion. Any scarring alopecia should be “burned out” prior to considering hair transplantation. In general, the condition should be quiescent for at least one year documented by resolution of inflammation by biopsy. Ideally, this biopsy should be compared to one obtained during active inflammation. The patient should be notified that if the condition is reactivated, the transplanted hair can be lost.

Folliculitis. Resolution of folliculitis should occur prior to considering transplantation.

General Considerations

Often multiple procedures are required to attain the desired density. The patient should be advised that one procedure may not create satisfactory density and that the transplanted hair

will be harvested from the scalp and will grow at the same rate as scalp hair. This may necessitate more frequent trimmings than usual for facial hair. Also advise the patient that the texture and color of the transplanted hair may differ from native hair in the area due to its relocation from the occipital scalp.

Many important structures exist in the face. It is important to know the location of all vital nerves, vessels, glands, and ducts. Specifically, the locations of the parotid gland and its duct, the trigeminal nerve, the facial nerve, and all facial vessels must be considered prior to undertaking these procedures. Informed consent should be given to the patient as to the possible consequences of damage to these vital structures.

General principles used in scalp hair transplantation concerning pre-operative screening for systemic disease, reaction to anesthesia, pre-operative medication, timing of repeat procedures, graft preservation, and post-operative care should be applied to facial hair transplants.

Anesthesia Regional Anesthesia

Nerve blocks are useful when performing beard, moustache, and/or peri-oral hair transplantation. A solution of 0.375% Bupivacaine/2% Lidocaine in a 3:1 proportion is infiltrated at the following locations:

Upper lip. Maxillary nerve, its terminal branch, the labial nerve, which exists below the infraorbital canal in the

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Beard and Moustache HT

continued from page 477

midpupillary line or in the sagittal plane, approximately 2.5cm from the midline, 1.0cm above the upper lip. Inject 0.5–1.0cc of above mentioned solution.

Lower lip. Mandibular nerve, its branch, the inferior alveolar nerve and then mental nerve (sensory only), which exits its bony canal in the midpupillary line or in the sagittal plane, approximately 2.5cm from the midline, 1.0cm below the corner of the lip. Inject 1.0cc of above mentioned solution.

Beard. Maxillary and mandibular nerves are both anesthetized. Local infiltration by field block is necessary to anesthetize areas not affected by the nerve block.

Local Anesthesia

Field block anesthesia using direct infiltration of marcaine and/or lidocaine can be used alone or in combination with nerve blocks. If nerve blocks are used, it is still generally necessary to infiltrate an epinephrine containing solution for vasoconstriction due to the high vascularity of the facial region, especially in the upper and lower lips. It is important not to exceed the recommended dosage of any anesthetic used. It is also important to accomplish anesthesia and limit bleeding to be able to place the transplants as atraumatically as possible. The author uses a combination of regional and field block anesthesia.

Procedure

Donor harvesting. An appropriate number of occipital donor follicles should be harvested employing the method used by the physician for scalp hair transplantation. An attempt should be made to match the texture of existing facial hair to occipital donor hair. Often native facial hair is more coarse than occipital scalp hair. Follicular units can be counted prior to harvesting to avoid removing excess follicles. The number of grafts needed

will vary greatly depending on the area to be treated and the number of existing hair follicles if any.

Donor dissection. Microscopic dissection is advised. Generally grafts should contain one follicle only with the exception of low diameter hair in which case two-hair follicular units can be used in combination with one-hair grafts. Two-hair grafts can be used in central areas to create density and should be avoided at a skin/hair interface. To create single-hair grafts, follicular units greater than one hair need to be divided. The grafts should be trimmed of excessive soft tissue and made thin to facilitate placement. Some peri-follicular soft tissue should remain for survival but this should be minimal.

Incisions. Incisions can be made with a variety of instruments including hypodermic needles, sharp point scalpels, and a variety of blades. It is important that the width of the incisions matches the size of the graft and is not too large or small. Incisions can be made perpendicular or parallel to the skin surface. Due to skin laxity in the facial area, application of counter traction is helpful when making incisions. It is very important to make the incision in the direction of existing hair. If no hair is present, one can look at another person with facial hair to determine the correct incision angle. The angle can vary greatly in a side-to-side orientation, from location to location, and can change quickly in adjacent locations. An acute angle downward is important to mimic existing angles and especially important to avoid damage to vital underlying structures. Tumescence can be used to lift the dermis and epidermis from underlying vital structures. If local anesthesia is used, this may accomplish sufficient tumescence. The author does not use tumescence. Growth that does not mimic the acute downward angle of native hair is undesirable. In comparison to scalp hair transplants utilizing one-hair grafts, the author makes the incisions

slightly wider and deeper to facilitate graft placement.

Spacing between and among incisions should be sufficient to create as much density as possible while allowing for atraumatic placement without popping during placement. Taking into consideration graft size, graft length, and tissue turgor, the distance between grafts will vary among patients.

Graft placement. After healing it is important that the skin have a smooth skin surface with no depressions or elevations. Both can cause an unnatural and noticeable skin surface. In addition, the patient must be able to shave the area if desired without causing trauma or bleeding. If elevated tissue is present, shaving could be difficult and painful. The author has found that leaving the graft's epidermis slightly elevated (0.5mm) with respect to the skin surface (1) prevents visible depressions when healed (2) marks the incision with a placed graft preventing "piggy-backing" and (3) leaves a smooth surface as the epidermis sloughs during healing. Meticulous, atraumatic placing is necessary to prevent skin surface alterations and increase the likelihood of graft survival. To accomplish this, the correct incision angle must be followed during placement. Due to skin laxity in the facial area, application of counter traction is helpful when placing.

Sufficient lighting and a comfortable position for the surgeon are important. The patient is in the supine or reclined position.

High patient satisfaction is achievable if patients are chosen correctly and meticulous attention to detail is given during the surgical/mechanical aspects of the procedure. Vital anatomic structures should be respected and naturalness reproduced. ♦

The Dissector

An article by anonymous



It was a chance meeting. Principles was at one of the medical instrument booths at an ISHRS Annual Meeting. He was looking for some of the highest quality instruments available from the vendor when he bumped into Paycheck who was heading for the least expensive side of the booth. They never had much in common but, for some reason, they struck up a conversation.

Paycheck: I see you are still wasting your money buying this expensive stuff. Don't you realize that these inexpensive instruments are almost as good? With the money you would have saved over the years, you could have bought a new car. The patients don't know the difference anyway.

Principles: I couldn't have a clear conscience unless I felt that I had done the best I could for my patients, and this includes the best instruments. Not only do they allow you to operate more precisely, but they send a message to your assistants that you are committed to quality work, which includes both your assistants and your instruments.

Knowing that they are working for you because they do quality work gives them a feeling of satisfaction. **Paycheck:** That is a bunch of baloney. My assistants are there for the paycheck just like me. Most of them are uneducated and move from job to job frequently. This is fine with me because they never rise to the point that I have to pay them a lot of money, and often they don't stay long enough that I have to put away retirement funds for them.

Principles: That may be true with your assistants, but not with mine. My assistants all have some level of nursing training and some have their ACLS certificate. I don't mind paying them a good salary as they are valuable to patient care. Most have worked with me for 5 years or more and attend the annual meetings. Sometimes I will send them to other offices to learn different techniques in order to see if these skills would help in our practice. Most of them look forward to learning the best techniques and are quite accomplished in using microscopes.

Paycheck: I am glad you brought that up. What a waste of money! Our assistants can see just fine with loupes and most do well with no magnification at all. And they are fast! Do you know that some can make 500 grafts in an hour, and they are perfect.

Principles: How do you know they are perfect? Did you ever look at them under a microscope?

Paycheck: Uh, no. I don't have a microscope. But I look at them using my bifocals sometimes.

Principles: Enough said. But don't you advertise that you perform follicular unit grafting? Also, I see that you advertise that you are Board Certified.

Paycheck: Well, we "sort of" do follicular unit transplanting. Anyway, that term is just a catch phrase used for advertising. We mostly do a technique called follicular "herds." Most of our grafts contain 7 or 8 follicular units in our "herds"—then we put them into a hole. We can cut and plant these as fast as everyone else does these so-called follicular units. A session takes 2–3 hours and it allows us to do 8 transplants a day. They might be a little clumpier than your version of follicular units, but we just put the bigger ones in the middle. You never see them unless it is windy. About the board certification, I am Board Certified in Gynecology, so I am not lying. I just advertise that I am a Board Certified Hair Transplant doctor. Who cares? If you advertise aggressively, you will make good money no matter what. I'll bet you don't even advertise.

Principles: You're right. I don't think it appropriate for doctors to advertise. It's unprofessional. We were always told that the worst doctors advertise.

Paycheck: Good luck while starving. I advertise in the newspapers and phone books, on TV, radio, and the Internet. I like the Internet the best because it is cheaper and less restricted.

Principles: I have seen your advertisements and have checked out your Website. Does it really bring in a lot of patients?

Paycheck: You bet. I see 7 consults a day and most come from Internet surfers. How many consults do you see each day?

Principles: Umm, 1 or 2.

Paycheck: Now you see my point. Don't spend your time going to all these stupid meetings. They don't make you any money. Spend it on advertising, particularly the Internet. I am a sponsor and recommended hair surgeon on 3 different Websites. They all say that their group is the best in the world. Whether we are or not, patients eat it up and worry about anyone not on the recommended list. They tend to forget that you have to pay before you get on that list. Patients also love the chat rooms.

The great thing there is that you can flood these chat rooms with anonymous testimonials to your work. Since they are anonymous, who can prove they are real?

Principles: I may have to rethink my position on advertising, but some of it seems sleazy. About these chat rooms—what if no one gives testimonials for you?

Paycheck: Man, you are dumber than I thought. Ask someone or pay someone to send them in. Heck, just send them in yourself. You can send in under different names so that it looks like a whole bunch of people think you are great. Every time someone asks for a good doctor, make sure your name gets sent in. When they hear your name enough times, they will take it for granted that you are good. Your name should be mentioned on every site at least once each day. Another fun thing to do is send in, or have someone send in, messages bashing your competitor—anonously, of course. It can sometimes help as much as positive testimonials about you.

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Dear Members,

We are pleased to present the 2003–2004 ISHRS Officers and Board of Governors. We anticipate another busy and successful year. Feel free to share your comments, suggestions and concerns. Please note that the Bylaws and Code of Ethics were revised at the General Membership Business Meeting held in New York on October 17, 2003. The current versions are available on the ISHRS Website (www.ISHRS.org) or by contacting the headquarters office. Best wishes to all for a prosperous New Year!

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The Dissector

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Principles: I just can't do that. It's not right.

Paycheck: Hey—this is a dog-eat-dog business. I really like to get after the big chains that have been around for years. Whenever their name is mentioned, I have someone send in a post reminding them that 15 years ago they did plugs and scalp reductions on everyone.

Principles: But wasn't that the state-of-the-art back then? Nearly everyone

did those procedures 15 years ago.

Paycheck: I must be talking to a wall. This is not about fair, it is about competition! You use anything you can. You'll get used to it.

Principles: Sorry, not me. I just want to do good work, stay friendly with my colleagues, and be ethical. I figure if I am good enough, patients will find me.

Paycheck: That's too bad. I was hoping you could have a condo next to mine on the beach one day. Besides, how can you

do great work on people when you don't schedule many surgeries? Sure, you can build a practice slowly, but you can build it fast with aggressive advertising. You spend all your money on equipment, assistants, and meetings but the public thinks I am one of the world's best. What do you get out of all your effort?

Principles: I sleep well at night. ✨

Surgical Assistants Corner



“Have no fear of perfection - you’ll never reach it.”

—Salvador Dali

Performance Appraisals: Striving for Perfection

Dear Surgical Assistants:

Performance Appraisals can be a time of much anticipation and nervousness on the part of the employee. If it is used by the office to determine raises, it is a time of reward and perhaps even disappointment. Both parties in the appraisal must be ready to discuss all areas of performance in an effort to communicate goals, accomplishments, needs for improvement, and any personal issues that might have an impact. It should be a time of objective and constructive criticism, and a review of the standards needed for success. It should never be a surprise to any one individual. Your performance as an employee should have been discussed on a more regular basis and, therefore, this time is more like a review of what you already know. Your performance as a supervisor should be reflected in the fact that this is not a surprise to the employee. Success is based on continual communication between supervisor and employee. Demands for change should occur at the time that it is needed and reiterated at the appraisal. If done correctly, performance appraisals are used as guidelines for future performance, and a checklist of goals that when reviewed in the future, should show improvement. I have included a few tips to keep in mind when preparing your performance appraisal. Of course, I am not the authority. You need to adapt this and any information to your specific clinic and setting.

This issue of the *Forum* is the last of 2003. I am taking the liberty to give you some thoughts on Performance Appraisals, both from a management point of view, and from an employee point of view. Both are extremely valuable. And only my opinion! At the writing of this note to you, we have not been to New York, and therefore at this time I cannot comment on what 2004 will be like. I am hopeful that the topics we cover in 2004 will be exciting and will be from all of you. As I have stated in previous journals, this Assistants Corner is for you and needs to be by you. I am excited about what all of you will do to make it *your* Corner in the coming year. I want to thank all of the contributors that have helped this year in bringing forth the Assistants Corner. I appreciate all of the support and positive feedback that I have received from everyone this year. I extend my wishes for a very prosperous and happy New Year. ✧

*Shanee Courtney, RN
Englewood, Colorado*

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Avoid having your ego so close to your position that when your position falls, your ego goes with it. —Colin Powell

.....

All correspondence for *Surgical Assistants Corner* should be directed to Shanee Courtney, RN, at:
Shanee Courtney, RN • E-mail: scourtneyrn@aol.com

Tips for Successful Performance Appraisals

Have them!

- ☒ Yes, that's right! You must schedule them regularly to be able to effectively communicate with your employees. In the first year, try to give feedback often to review the standards you expect. After the first year, annual reviews should be sufficient unless you are having challenges that need attention.
- ☒ If you are an employee who has not had feedback consistently, do your own! Submit an appraisal of goals, where you feel you need to improve, and where you feel you have excelled. It might just stimulate some great conversation.

Be prepared!

- ☒ Both manager and employee need to go into the meeting with an idea of areas of improvement, areas of achievement, and goals. Standards should have already been reviewed so that both parties understand what was expected.

Be enthusiastic and expect a positive outcome!

- ☒ Unless there have been major problems that have been discussed, performance reviews should not be

filled with surprises. It should not be the objective of the manager to "bait and switch." A successful employee reflects well on the manager, an unsuccessful employee reflects a failed attempt on both parts. Make it successful.

Embrace confrontation!

- ☒ I know that this is a weird one. Confrontation is difficult in almost every office. However, confrontation is an opportunity to understand one another's point of view. It clarifies points of confusion, and bridges gaps in communication.
- ☒ Both managers and employees should remember to not let it become personal. Practice good listening skills.

If it becomes negative, stick to the objectives and standards!

- ☒ Everyone in this business is interested in great results and excellent patient care. Those objectives are the most important values that we have in common. *How* we get there is what encompasses the standards we set. If an appraisal is negative, it is usually because there is a compromise in one of these values. Perform

good problem-solving methods to identify what has caused the conflict and why.

Restate your goals both as the employee and as the manager!

- ☒ Restating and refocusing the objectives of the appraisal from the perspective of the manager and the employee help to verbalize what the employee intends to work on and what the manager plans to do to help. Get agreement between both parties so that an alliance has been formed.

Set up a time for the next meeting!

- ☒ If an appraisal is awesome, you may not need to meet until the next year, formally, unless there is a change in job function or job performance. If the appraisal has objectives to work on, a more prudent idea is to have a follow-up meeting within 1–3 months to review success or the need for further review.
- ☒ Employees may need to be proactive with managers to make sure they make time for follow-up. When you feel that there is miscommunication occurring, set a meeting to "get on the same page." ♦

MESSAGE FROM THE SURGICAL ASSISTANTS CHAIR

Dear Surgical Assistant Members,

I am pleased to accept the honor of chairing the Surgical Assistants meeting being held in Vancouver, BC, Canada, August 11–15, 2004, at the Westin Bayshore Resort. I am very excited and look forward to meeting many of you at that time.

I have worked for Dr. Michael Beehner in Saratoga Springs, New York, for the past 4 years. I am a LPN and have a wide variety of tasks to perform such as scheduling and assisting Dr. Beehner as well as post-op hair washes and suture removals.

The New York meeting was wonderful and the turnout was one of our best ever with the number of registered assistants reaching 210. I especially enjoyed the open discussion area with the questions from the baskets. We would like to continue and expand on that idea by having anonymous submissions of post-op complications that you have had occur in your office. This is just one of the ideas that the Vice-Chair Cheryl Pomerantz and I have been talking through. We welcome any suggestions on how to make this an informative and educational experience. Our goal is to bring back some of the scientific aspects of being an assistant as well as address some of the pressures and stresses that I know we are all feeling in this hectic world.

Please remember that this is our meeting and it can be as great as we want to make it. It is up to you to get involved and make a difference. If there is something that you are interested in or would like to hear about, please contact either Cheryl or me. I encourage all of you to give a presentation or simply write a submission for the *Forum*. I know that we have a lot of knowledgeable, talented members that we have not heard from yet.

Let your voice be heard! We are listening.

Sincerely,

Betsy Shea

Email: betsyoshea226@yahoo.com • Phone: 800-281-9198 • Fax: (518) 583-7444



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Upcoming Events

Following is a guide to upcoming meetings and workshops related to hair restoration. For more information, contact the appropriate sponsoring organization at the number listed. Meeting organizers are reminded that it is their responsibility to provide the *Forum* Editors with advance notice of meeting dates.

Date(s)	Venue	Sponsoring Organization(s)	Contact Information
December 5–6, 2003	New York Hair Symposium 2003 The Plaza Hotel <i>New York, New York USA</i>	Marc R. Avram, MD, Chair	Tel: 212-734-4007 Fax: 212-734-4321 E-mail: info@dravram.com
March 10–13, 2004	10 th Annual Live Surgery Workshop, <i>Orlando, Florida, USA</i>	International Society of Hair Restoration Surgery	Tel: 407-333-4200 Fax: 407-333-2140 E-mail: lmgvalmont@aol.com
March 13–14, 2004	ABHRS Board Exam, <i>Orlando, Florida, USA</i>	American Board of Hair Restoration Surgery <i>www.abhrs.org</i>	Tel: 708-474-2600 Fax: 708-474-6260 E-mail: ambrdhrs@cs.com
May 20–23, 2004	7 th Annual Meeting & Live Surgery Workshop, <i>Florence, Italy</i>	European Society of Hair Restoration Surgery (ESHRS) <i>www.eshrs.org</i>	Tel: 33-1-45-00-00-76 Fax: 33-1-45-02-15-77
June 3–5, 2004	9 th ISHR International Congress <i>Torino, Italy</i>	Italian Society for Hair Restoration <i>www.actacongress.com</i> or <i>www.ishr.it</i>	Organizational Bureau Tel: 39-011-591871 Fax: 39-011-590833 E-mail: acta@actacongress.com
August 11–15, 2004	12 th Annual Meeting of the ISHRS <i>Vancouver, BC, Canada</i>	International Society of Hair Restoration Surgery <i>www.ishrs.org</i>	Tel: 630-262-5399; 800-444-2737 Fax: 630-262-1520

To Submit an Article or Letter to the *Forum* Editors

Please send submissions via a 3½" disk or e-mail. Remember to include all photos and figures referred to in your article as separate attachments (JPEG, Tiff, or Bitmap). For e-mail submissions, be sure to ATTACH your file(s)—*DO NOT* embed it in the e-mail itself.

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