The Dissector

Russell Knudsen, MBBS *Sydney, Australia* drknudsen@bigpond.com

In the continuing debate about the AR genetic test (HairDx.com), Dr. Cam Simmons has submitted his further thoughts. Dr. Sharon Keene has again graced us with a reply. This will obviously not be the end of the matter as AR genetic testing will surely become part of our landscape and require us to decide where it fits in our management plans. We should, of course, expect our opinions to change with the accumulation of further evidence. Reassurance of young, anxious men who are psychologically traumatized and feel they are in an "information vacuum" is an important subject, and possession of any new knowledge is somewhat empowering to the patient.

The clinical utility of the AR genetic test

Cam Simmons, MD *Toronto, Ontario, Canada*

After Dr. Sharon Keene's excellent reply regarding the predictive value of the AR genetic test (*Hair Transplant Forum Int'l.* 2008; 18(6):232), I now understand I am more concerned about the clinical utility of the AR genetic screening test than the clinical validity: "Clinical Utility in its narrowest sense refers to the ability of a screening or diagnostic test to prevent or ameliorate adverse health outcomes such as morbidity, mortality, or disability through adoption of efficacious treatments conditioned on test results."[1]

In other words, would knowing the results of the test truly help our patients? Would it motivate patients to seek help sooner? Would it change our treatment plan to stabilize hair loss earlier? Would it relieve anxiety?

Do the Makers of HairDx™ Themselves Know How to Use This Test?

When I wrote my original letter in September 2008, HairDx.com discussed the test as a means to detect early-onset hair loss: "The variant AR is found in more than 95 percent of bald men—60 percent of men who have the variant AR will develop baldness by age 40. HairDx also provides information on a less common AR variant that predicts a very low risk of early-onset androgenetic alopecia—more than 85 percent of men who have this variant will not have hair loss by age 40. Men who test positive for the variant AR should be advised that they are at a high risk of developing early-onset Male Pattern Hair Loss."[2]

Now, the website states "Men who test positive have approximately a 70% chance of going bald.... Men who test negative have approximately a 70% chance of not going bald."[3] The intended role of the test has clearly changed since HairDx came to market. Lifetime prevalence is now more appropriate, so Dr. Keene's calculations would apply.

Simple Numbers

Considering the pooled data and Dr. Keene's calculations, 85.3% of the general population will have AR gene allele G and 14.7% will have allele A. Using a lifetime prevalence of developing AGA of 63%, the pre-test likelihood of going bald is 63% and the pre-test likelihood of not going bald is 37%. Using Baye's theorem, Dr. Keene established that the presence of allele G increases the risk of going bald to 68% and the presence of allele A increases the chance of not going bald to 69%. On the surface, having allele G doesn't seem to change your odds that much but finding allele A could make a big difference.

Applying the Numbers

To keep things simple I am going to hypothesize about 100 random 20-something-year-old men with no clinical signs of hair loss. Eighty-five of these men will have allele G and 15 will have allele A. Of the men with allele G, 58 will go bald and 27 won't. Of the men with allele A, 5 will go bald and 10 won't.

Will the HairDx Test Relieve Anxiety?

We can explain about probabilities but patients tend to see test results as "yes or no."

Of 100 men who take the test, 15 will be told that they have allele A, 10 will have been given real reassurances but 5 will have been given false reassurance.

Of the 100, 85 will have allele G. Only 58 of them will go bald but all 85 will worry more than they would have if they hadn't taken the test. The test does not tell them how bald they will go or how fast.

Can the HairDx Result Save Hair?

Medical stabilization is a long-term maintenance program. The effect is lost after the medications are stopped. I would not hesitate to recommend medical treatment when there are very early signs of hair loss. I would not advocate having 37 out of 100 men take unnecessary lifelong treatment so that the other 63 could prevent hair loss.

My usual treatment for someone who has no clinical signs of hair loss would be to take photos and Microvid photos then to invite them to return in a year to see if things have changed. They can come earlier if they feel they have lost hair. If I catch someone when he and I are the only ones who notice miniaturization, there will still be lots of hair on which the medications could work.

Obviously, finding allele A won't lead to any different action. I can't tell them to go away and never come back because 30% could still go bald.

What would we do differently if a patient has allele G? His chance of going bald has increased but only from 63% to 68%. Changing the ratio from 63:37 to 68:32 is not a tipping point for me. With or without the test result I would wait until there were early signs of hair loss before initiating treatment.

Could the HairDx Test Precipitate Earlier Medical Attention?

As a generalization, men don't go to doctors if they feel healthy but they also don't do tests unless they are worried. The people who would choose to do the HairDx test based on their family history or fear of balding are already motivated and vigilant. I suspect that they are the patients who would see their doctor when they noticed early hair loss (but I don't have any proof of this).

Conclusion

In my opinion, a test that is correct 70% of the time is not a good test. The HairDx test result will not alleviate patient anxiety appropriately or affect my treatment plan for any patient. If a test result has no positive impact, there is no point in doing the test in the first place.

A Response from Sharon Keene, MD

**Dr. Keene serves as the Chief Medical Officer for HairDx.*

First, I feel it important to correct any misimpression that I personally made the calculations regarding the clinical validity of the HairDx test. I did not, and make no claims to be a biostatistician. The calculations were confirmed by Dr. Nathan Vandergrift, professor of biostatistics at Duke University. For clarification, I never represented in my lecture or *Forum* article that the HairDx male AGA test was capable of determining onset for AGA, though some of the supporting articles made that implication. I anticipate additional genetic research and findings will assist in our ability to predict onset, and the company website will continuously reflect changes and updates based on prevailing information. It must be acknowledged there are limitations to *any* screening test. A perfect test will have 100% positive and negative predictive value, but such a test would then be considered a diagnostic test and that distinction was previously made. Screening tests are used to inform patients about risk prior to the onset of symptoms, in order to change behavior or institute therapy earlier to prevent or treat the condition more effectively.

In regard to clinical utility of any screening test, they have none if they are never used. If "wait and see" were an effective treatment option for hair loss, we would never hear patients say they wish they had known about treatment options years ago when it would have made a greater difference. Dr. Simmons asserts it is enough to provide annual follow-up on a patient who is vigilant. Is that really the optimal approach? Although traditional models of AGA suggested a step-wise process of miniaturization, which might allow the opportunity for a patient experiencing hair loss to investigate their options in a slow, methodical fashion, more recent evidence suggests the progression from terminal to vellus hairs can occur in an abrupt large-step process.[1] In my practice I have seen both gradual progression and rapid massive hair loss. The latter does not allow time for trial and error for affected patients. Hair loss therapies are most effective at preventing hair loss rather than restoring hair, which makes the strategy of waiting for hair loss to occur less desirable. Hair restoration doctors have the opportunity to influence patients based on the way they "frame" information about hair loss therapy. This "framing" effect has been studied, and patients can be influenced to pursue or avoid therapy depending on the information offered, and the way it is offered.[2] One can discourage early medical treatment, and even discourage all medical treatment for hair loss. Most of us would find this to be a compromise of our medical ethics based on current safety profiles and efficacy of medication for the majority of patients. A randomized trial revealed that tailoring health information and personalizing risk can significantly impact a patient's behavior toward ameliorating a particular health risk, or in this setting, pursuing effective medical treatment.[3] The real challenge then, is to find a way to personalize risk and educate patients, knowing many patients see some family members are affected but others are not, etc. If we are concerned about the cost of testing or the cost of unnecessary therapy, these costs must be fairly balanced with the cost of not treating (hair loss, psychosocial impact, long-term hair replacement costs, hair systems, etc.) and billions of dollars spent on ineffective therapies.

References

1. Grosse, S., and M. Koury. What is the clinical utility of genetic testing? *Genet Med.* 2006; 8(7):448-450.
2. What will the results mean for me? http://hairdx.com. September 15, 2008.
3. What will the HairDx test tell me? http://hairdx.com/GeneticTestMale.aspx. December 11, 2008.✧

Letters to the Editors

Melvin L. Mayer, MD *San Diego, California*
Re: Follicular Regeneration of Transected Follicles

An interesting article entitled "Hair regeneration from transected follicles in duplicative surgery: rate of success and cell populations involved" has been recently published in Dermatologic Surgery by Toscani, et al. (Sapienza University of Rome).[1] From each of 28 patients 100 hair follicles were horizontally bisected and implanted. Transection was below the arrector pili muscle; the procedure was standardized by cutting all follicles at one-third of their length from the papilla. Toscani's counts at 12 months observed 72.7% growth from the upper segments, and 69.2% from the lower segments.

Their results were almost identical to mine, which I reported at the 1998 ISHRS Annual Meeting. My level of cut was very similar to theirs below the arrector pili muscle in the area of the bulge, approximately one-third their length from the papilla. My data on a single patient using 161 upper and 161 lower segments at 9 months: the upper segments produced 102 hairs (63.4%), and the lower segments produced 113 hairs (69.1%).

They also noticed a decrease of about 20 microns in the diameter of the bisected hair follicles. This observation led me, along with Drs. Kim, Martinick, Beehner, Barusco, Perez-Meza, and Leavitt to do a study at the 1999 Orlando Live Surgery Workshop using bisected hairs in the one half of the frontal hair line compared to intact hairs on the other half. Observations at 9 months resulted in the patient observing equal naturalness between the two sides and the blinded observers thought there was increased naturalness on the bisected side.[2] In 2001 Swinehart also reported on using bisected hair follicles to create finer hairlines.[3]

I find the surgeon has difficulty controlling the placement angle of bisected hairs, also, it is difficult to determine if the recipient site is filled when one bisects single follicles for the frontal hairline. It is my observation that one can consistently produce natural hairlines by using intact "finer singles" in the frontal edge of the hairline. However, no one knows if these "finer singles" remain the same diameter through subsequent hair cycles.

References

1. Toscani, M., et al. *Derm Surg.* 2009; 35:119-1125.
2. Mayer, M., et al. *Int J Cos Surg and Aesth Derm.* 2001; 3:135-138.
3. Swinehart, J. "Cloned" hairlines: the use of bisected hair follicles to create finer hairlines. *Derm Surg.* 2001; 27:868-872.✧

Sara Wasserbauer, MD *Walnut Creek, California*
Re: Dr. Rassman's Article on Unethical Behavior

Dr. Rassman's article "Areas of unethical behaviour practiced today" (*Hair Transplant Forum Int'l.* 2009; 19(5):149) was both timely and accurate since I, too, have seen a recent increase in unprofessional behavior. To his list I would add two more common practices that I have noticed were on the rise:

1. Selling fewer grafts than a patient needs just to get them in the door. If a patient asks for full head coverage and is given a quote for 1,000 grafts and told it will meet their goals is not only misleading, it is unethical. I have found that this behavior is either due to the fact that the true cost of the procedure the patient is requesting would seem high and the office is worried they would not "close" that "sale," or it is simply due to the fact that the office does not have the manpower or skills to perform the surgery the patient needs. Additionally, the next physician who suggests more grafts are needed looks greedy by comparison. This is the corollary to "selling and delivering more grafts than the patient needs," and equally damages the trust in our profession.
2. Disparaging the work of other hair surgeons. The economy may be down but professional standards do not change with our fortunes. Unless you are witnessing treatment that is clearly below the standard of care (in which case you have an obligation to act in the patient's best interests), you, your staff, and your consultants, should refrain from judgmental remarks including those regarding graft counts or artistic sense. We all practice just a little differently and it is a fair bet none of us know the full circumstances of any previous hair transplant unless we performed it ourselves. Highlight instead what your approach would be and how expertly your practice cares for its patients.✧

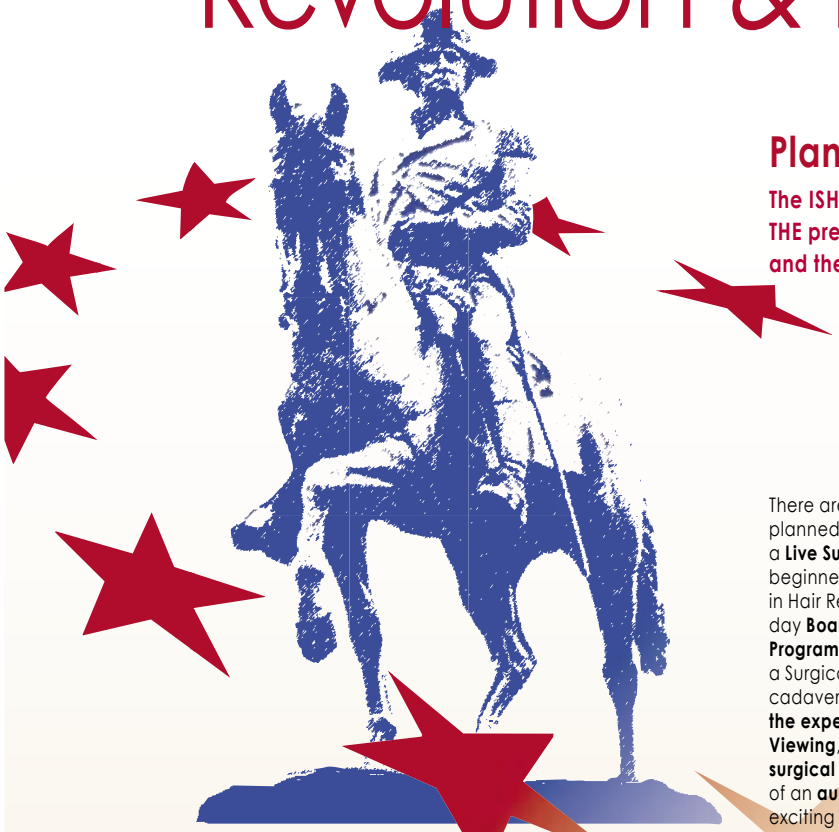
IN REPLY

William Rassman, MD *Los Angeles, California*
Re: Response to Dr. Wasserbauer

Lowballing professional fees to meet the budget of a prospective patient buyer has been around since before I entered the hair transplant business in 1989. Likewise, demeaning other physicians to "elevate" a sleazy physician's sense of worth to the prospective buyer is as old as the medical profession itself as it goes beyond business and dives into personalities and egos. Every box of apples has a few rotten ones and the challenge, of course, is to seize the moment to expose the unethical activity of the predatory physician, at a minimum. I have created baldingblog.com as a foundation for a campaign for patient education and I am always careful to focus on the immoral practices that the patients write to me about, never mentioning any physician's name. Creating an educated buyer to flush out the rotten apples in our field is at the core of what each of us can do.✧

Advances in Hair Restoration: Revolutionary Concepts and Evolutionary Techniques

Revolution & Evolution



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Newcomers Are Welcome! As a result of the positive feedback from the 2009 annual meeting, we will again offer a "Meeting Newcomers Program" to orient those who are new to the ISHRS annual meeting. Newcomers will be paired with hosts. We want to welcome you, introduce you to other colleagues, and be sure you get the most out of this meeting.

Submit An Abstract A variety of abstract will be considered. Choose from four distinct types of abstracts:

1. Scientific study abstract
2. Abstract on a position or controversy *(e.g., How do you feel about body hair transplants? Dense packing? FUE? Trichophytic closure?)*
3. Abstract for a high definition video for the Video Surgical Theater
4. Abstract for a Live Patient Viewing Case

TO SUBMIT AN ABSTRACT GO TO:
www.ISHRS.org/18thAnnualMeeting.html
and click on **Submit an Abstract** to get started

SUBMISSION DEADLINE: FEBRUARY 15, 2010

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Details and additional information about the meeting can be found at: www.ISHRS.org/18thAnnualMeeting.html

Message from Paul J. McAndrews, Program Chair of the 2010 Annual Meeting

Dear Colleagues:

I am honored to have been invited to serve as the Program Chair for the 18th Annual Scientific Meeting of the International Society of Hair Restoration Surgery. I am very excited about our keynote speakers who have agreed to speak—Drs. Bruno Bernard and Kurt Stenn. The meeting is coming together quite nicely. This year we will have a lunch symposium with topics including **Social Media**, **FUE**, and **Open Mic.** Meals will be served with these symposiums. We will also be having morning workshops with topics including FUE using cadavers, "hands-on" recipient site training, anesthesia techniques, and avoiding poor growth. We will again have the popular "Breakfast with the Experts."

The 2010 meeting will be held from October 20-24 in Boston, Massachusetts, USA, at the Seaport Hotel and World Trade Center. This year's theme is REVOLUTION & EVOLUTION—Advances in Hair Restoration: Revolutionary Concepts and Evolutionary Techniques.

I am confident the annual meeting will continue to improve secondary to the amazing involvement of our members in the ISHRS. I invite all of you to continue to be involved and submit one, or more, abstracts for consideration for presentation in Boston. There are a variety of abstracts that will be considered, and this includes the following four distinct types of abstracts:

1. Scientific study abstract (our usual format)
2. Abstract on a position or controversy (e.g., How do you feel about body hair transplants, dense packing, FUE, trichophytic closure, etc.?)
3. Abstract for a Live Patient Viewing Case
4. Abstract for the Video Surgical Theater in high definition

First is our conventional workhorse, the ***Scientific Study*** format, which is the standard most are familiar with. Next, a ***Position or Controversy*** abstract is being offered where you position your passionate stand on a technique or, perhaps, your feelings on a technique's lack of merit. The authors of these abstracts should present the logic and data behind their position and be prepared for active discussion from other panelists. Third is a ***Live Patient Viewing Case*** abstract. Here you should provide the details of the patient history before and after each surgery/treatment that contributes to the way the patient will present as well as include high-quality before-and-after photographs.

Lastly, abstracts are being solicited for the ***Video Surgical Theater.*** Here, too, the body of the abstract should describe the reason this particular technique is being proposed for projection. The quality of this session depends on expertly edited high-quality video clips of surgery that tell a specific story. The narration of the surgery should be in the video and not live. Presenters will field questions following the video; video clips will be reviewed before the venue. **We want all videos to be in high definition (HD), if possible.** For the "how to" insight into making your own great video, please refer again to Dr. Arthur Tykocinski's information-packed article "How to make a great surgical video in HD," which can be found in the November/December 2008 *Forum* (19(8):199) and on the ISHRS website.

The **deadline for abstract submission is February 15, 2010.**

We look forward to receiving your abstracts for review!

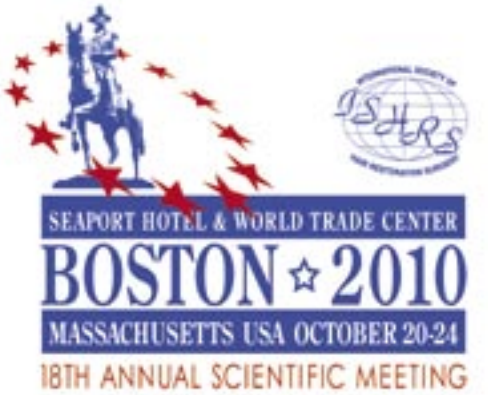
I am looking forward to creating a revolution in Boston in 2010 with all your help. Bringing tea is optional; however, coming from an Irishman, bringing beer is encouraged.

Sincerely,

Paul J. McAndrews, MD

Chair, 2010 Annual Scientific Meeting

DEADLINE FOR ABSTRACT SUBMISSION: FEBRUARY 15, 2010



Review of the

Literature: Facial Plastic Surgery

Sheldon Kabaker, MD *Oakland, California* HairflapMD@AOL.com

The high female hairline

Citation

Ramirez, A.L., K.H. Ende, and S.S. Kabaker. Correction of the high female hairline. *Arch Facial Plast Surg.* 2009;11(2):84-90.

Introduction

The female hairline is variable in position. In the ideal situation, the hairline is 5-6.5cm above the brows and usually begins at some point where the scalp slopes from a more horizontal position to a more vertical one. This allows for versatility with hairstyling and the aesthetic vertical thirds of the face are equal, providing facial harmony and balance.

In contrast, there are a number of women who have a hereditary high hairline (or big forehead). These patients have a hairline that is usually stable after puberty and have normal density and volume behind it. Many, however, are often unhappy with this situation. The appearance of a high hairline makes women look masculine and/or older than their years. The associated big forehead is unattractive and their hair styling is often limited to combing downward (bangs) for camouflage. Occasionally, the hairline is so high and posterior that the hair will exit the scalp at a less acute angle or even perpendicular to the ground. Hair thus does not fall effectively and the upper third of the face can be so disproportionate that patients appear to have hair on only the back half of the scalp. These women with high hairlines will often present to the transplant surgeon requesting lowering of the hairline.

Hair transplantation can be used quite effectively to treat these patients. Follicular unit grafting is an effective treatment that has a low incidence of complications and is certainly the standard for hair restoration work. This technique, however, is labor intensive, time consuming, and can be expensive, especially since these patients often require multiple sessions to achieve the 2-4cm of hairline lowering required with the full density acceptable to women. In addition, women may have to wait for 2-4 years of growth to see the full result after transplantation. We present an alternative technique that produces outstanding results rapidly, is readily acceptable to patients, and has rare complications.

Objective

To review a technique and to make quantitative analyses of the senior author's 20-year experience with his preferred technique to correct the high female hairline.

Procedure

The flexibility of the scalp and upper forehead is the single most important factor for success. We perform the procedure under intravenous sedation and local anesthesia.

A non-repeating, irregular trichophytic incision is performed within the fine hairs of the anterior hairline. We try to create a similar transition zone as seen in follicular unit grafting.

After the incision, the scalp is lifted and dissection in the proper plane is rapid and bloodless. In the forehead, dissection in the same plane is performed to just below where we want the hairline. The scalp is then advanced forward and the excess non-hair-bearing forehead skin is excised with an incision that is parallel to the beveled trichophytic incision. The wound is closed in two layers. To ensure a good cosmetic result, there is no tension on the skin closure. Other maneuvers such as galeotomies and the placement of one or two dissolvable tack-like devices (Endotines) are usually incorporated to get optimal results. A light dressing is placed and removed on the first post-operative day. A cosmetic result is appreciated immediately. The hair may be combed downward and there is minimal bruising and edema. Sutures are removed in 4-7 days.

Methods

A retrospective review of 29 female patients who underwent the hairline-lowering procedure performed by the same surgeon (S.S.K.). We analyzed preoperative and postoperative standardized photographs by taking measurements from the medial and lateral canthi to the anterior hairline. Facial height, from the menton to the hairline, was also measured. We calculated mean values and then used a 2-tailed, paired t test to evaluate for statistical significance. Patients also underwent evaluation for satisfaction, complications, and aesthetic result. We reevaluated the measurements from the profile view and compared them with the original data.

Results

The photographed mid-frontal hairline position was vertically lowered on average 1.3cm in patients who underwent a single-stage procedure ($p < .001$). In retrospect, the analysis was flawed compared with clinical experience. Therefore, the profile views were evaluated, and the correlating true curvilinear advancement was an average of 2.1cm. Three complications occurred, including 1 major effluvium, 1 minor effluvium, and 1 scar that required revision. Patient satisfaction was extremely high.

Discussion

There are two variations with this procedure that have proved useful. First, if the hairline needs to be advanced a large distance or if the scalp is tight, a tissue expander may be required. This is done as a staged procedure, with placement of the expander as the first stage and advancement of the hairline as the second stage. Typically, the bal-

⇨ page 33

Surgical Assistants Editor's Message

Laurie Gorham, RN *Boston, Massachusetts* *laurieg@bosley.com*

Happy New Year, Assistants!

I can't believe that we are starting another decade! Please keep your articles/submissions coming my way for publication. The exchange of ideas and information is so important. If you can take a moment out of your day, please drop me a quick note with "Pearls of Local Anesthesia." Do you use a massager to employ that old "Gate Control" theory? How does that work for you? Or you can offer any other methods of administering local anesthesia that work well for you and the comfort of your patients. Just a quick note…and we will compile the submissions and share in the next issue!

Thank you so much.

Keep warm…if you are in a chilly part of the world and if not…lucky you! Send some sunshine to the rest of us!

Laurie Gorham, RN

Editor, Surgical Assistant's Corner; Surgical Assistants Program Chair

Please email your "Pearls of Local Anesthesia" to laurieg@bosley.com.

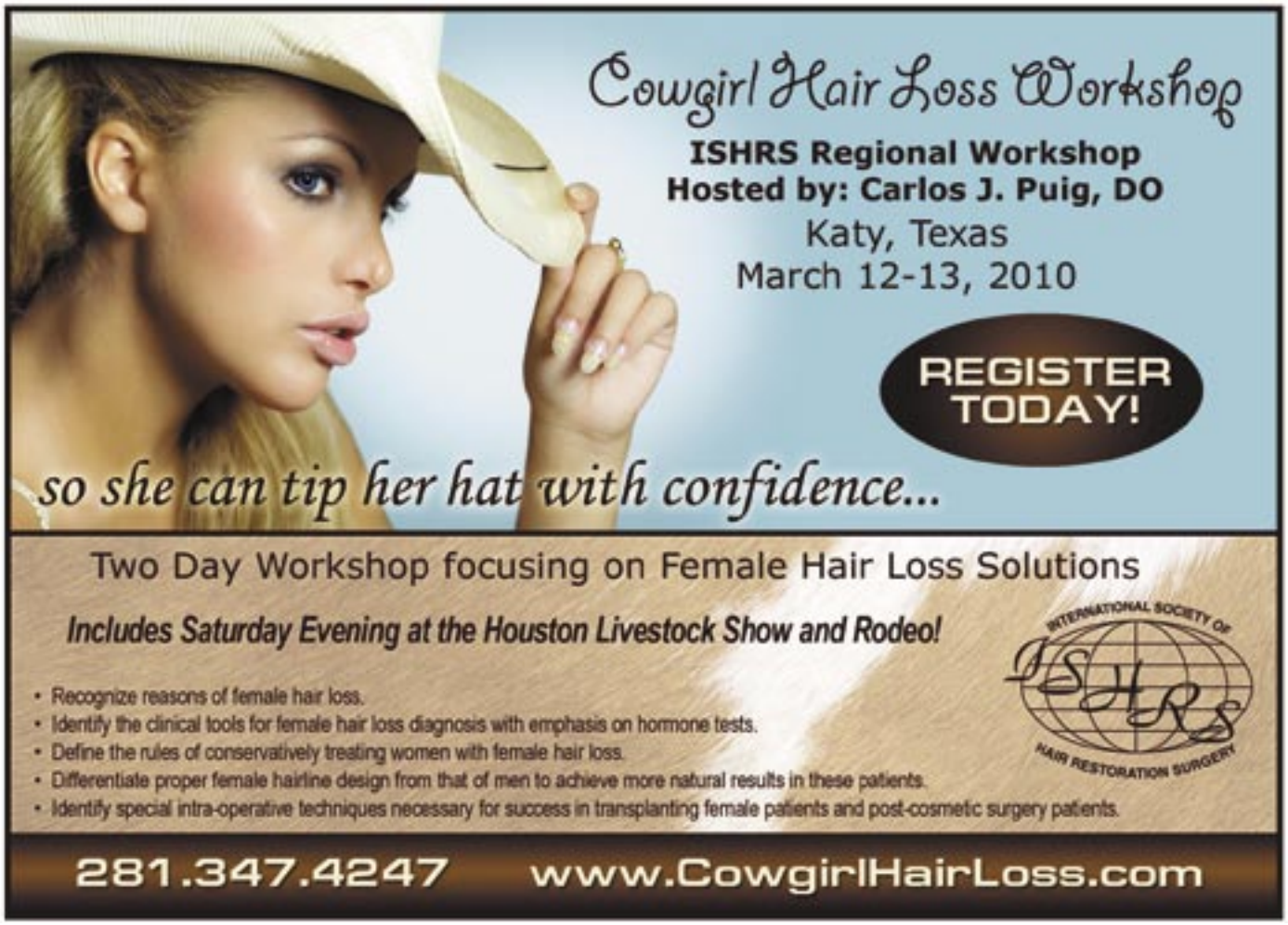
loon is expanded over a 6-week period (e.g., 75-100cc per week) to stretch the scalp sufficiently to allow for 4-6cm of advancement. This is well tolerated by patients aside from the increasing cosmetic inconvenience during the last three weeks of the expansion. Ten percent of patients tend to require this expansion process.

The second variation of this procedure is to combine the hairline advancement with a brow lift. For this procedure, the forehead dissection is extended below the orbital rims and the frown muscles may be cut or cauterized from their undersurface. Before the skin excision and closure, the brows are fixed at the desired level.

The most important concern with this technique for hairline advancement is the possibility of a noticeable scar. The technical points of the trichophytic incision are critical in avoiding this complication. Scars are generally concealed by this technique and hair grafts could later be performed if the scar were visible. This may be recommended preoperatively when there is a pre-existing cowlick at the hairline. Overall, patients tolerate this procedure very well. They always report decreased sensation of the frontal scalp, but this resolves by 6 months. Other complications, such as significant shock loss have been rare, no more so than with dense packed follicular unit grafting. The cost effectiveness of this procedure is significant when we consider time for hair growth and the absolute number of hairs moved. The average case of a 15cm hairline moved down 2.5cm relocates over 3,000 follicular units, or over 7,000 hairs. If scalp expansion is required, the cost effectiveness goes down somewhat on those with tight scalps but it is counterbalanced by the movement of much more hair in those who require greater than 3cm of movement.

Conclusion

Advancement of the female hairline by incorporating an irregular trichophytic incision and a posterior scalp advancement flap is an effective and safe technique that has been used by the senior author for more than two decades. The average advancement was 2.1cm in this study. The technique is immediately effective, well tolerated by patients, and associated with minimal complications. Although it is associated with a potentially visible incision, the trichophytic technique can be used to make the scar virtually invisible.✧



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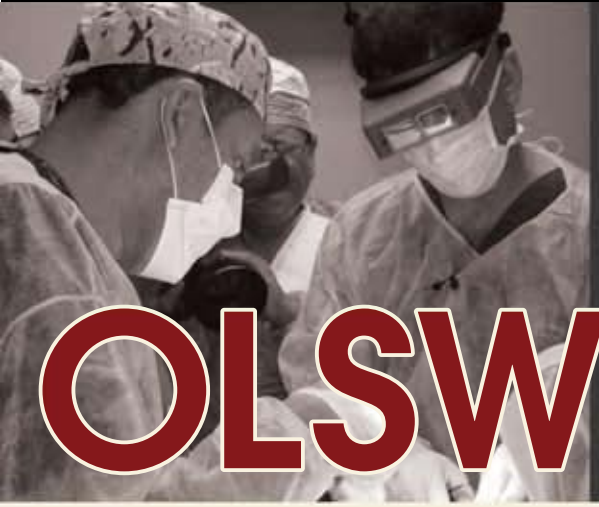

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LEARNER OBJECTIVES

Upon Completion of the Program, participants will:
- Understand the basic concept of hair restoration and apply this knowledge in practice.
- Understand the development of the latest techniques in hair restoration surgery and when they are best utilized for the patient.
- Evaluate the efficacy of hair loss medications and how to effectively use them in conjunction with surgery.
- Learn the various forms of alopecia, diagnosis techniques and the best approach to relevant treatments both medical and surgical.
- Comprehend the current data in genetic and medical research and its impact on hair restoration and patient care.
- Understand the various surgical techniques and their appropriate use with emphasis on follicular units, follicular extraction, scalp reductions, extenders, etc.

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INTERNATIONAL SOCIETY OF ISHRS HAIR RESTORATION SURGERY

Advancing the art and science of hair restoration

Upcoming Events

Date(s)	Event/Venue	Sponsoring Organization(s)	Contact Information
Academic Year 2009–2010	Diploma of Scalp Pathology & Surgery U.F.R. de Stomatologie et de Chirurgie Maxillo-faciale; *Paris, France*	Coordinator: Pr. P. Goudot Directors: P. Bouhanna, MD, and M. Divaris, MD	Tel: 33 + (0)1 + 42 16 13 09 Fax: 33 + (0) 1 45 86 20 44 *sylvie.gaillard@upmc.fr*
January 2010	International European Diploma for Hair Restoration Surgery	Coordinator: Y. Crassas, MD, University Claude Bernard of Lyon, Paris, Dijon (France), Torino (Italy), Barcelona (Spain). Department of Plastic Surgery *www.univ-lyon1.fr*	For instructions to make an inscription or for questions: Yves Crassas MD *yves.crassas@wanadoo.fr*
March 12–13, 2010	ISHRS Regional Workshop Cowgirl Hair Loss Workshop *Katy, Texas, USA*	International Society of Hair Restoration Surgery *www.cowgirlhairloss.com* Hosted by Carlos J. Puig, DO	Tel: 281-347-4247 *cpuig@HairDocTexas.com*
April 7–10, 2010	ISHRS Regional Workshop 16th Annual Live Surgery Workshop *Orlando, Florida, USA*	International Society of Hair Restoration Surgery *www.ISHRS.org/2009OLSW.htm* Hosted by Matt L. Leavitt, DO	Valarie Montalbano, Coordinator 407-373-0700 ext. 103 *HValarieM@leavittmgt.com*
April 14–17, 2010	Hair Restoration, Alpine Workshop *Le Chabichou Hotel* *Courchevel, France*	University Claude Bernard Lyon I, European Graduate Hair Diploma Society	Yves Crassas, MD *yves.crassas@wanadoo.fr*
May 20–22, 2010	XIII International Congress of ISHR *Capri, Italy*	Italian Society of Hair Restoration *www.congresso.ishr.it/*	*info@ishr.it*
June 25–27, 2010	ISHRS Regional Workshop New Advances in Asian Hair Transplantation *Bangkok, Thailand*	International Society of Hair Restoration Surgery *www.ishrs.org* Hosted by Damkerng Pathomvanich, MD	Dr. Damkerng Pathomvanich *path_d@hotmail.com*
July 23–25, 2010	2nd Annual Hair Restoration Surgery Cadaver Workshop *St. Louis, Missouri, USA*	Practical Anatomy & Surgical Education, Center for Anatomical Science and Education, Saint Louis University School of Medicine *http://pa.slu.edu* in collaboration with the International Society of Hair Restoration Surgery	*http://pa.slu.edu*
August 18–21, 2010	4th Scientific Meeting of the Brazilian Association of Hair Restoration Surgery *Belo Horizonte/Ouro Preto, Minas Gerais, Brazil*	Brazilian Association of Hair Restoration Surgery	*clinica@marcelopitchon.com.br*
October 20–24, 2010	18th Annual Scientific Meeting of the International Society of Hair Restoration Surgery *Boston, Massachusetts, USA*	International Society of Hair Restoration Surgery *www.ISHRS.org/18thAnnualMeeting.html*	Tel: 630-262-5399; Fax: 630-262-1520

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Dates and locations for future ISHRS Annual Scientific Meetings (ASMs)

2010: 18th ASM, October 20–24, 2010
Boston, Massachusetts, USA

2011: 19th ASM, September 14–18, 2011
Anchorage, Alaska, USA

2012: 20th ASM, October 17–21, 2012
Paradise Island, Bahamas

2013: 21st ASM, October 23–27, 2013
San Francisco, California, USA