Co-editors' Messages

Nilofer P. Farjo, MBChB *Manchester, United Kingdom* editors@ISHRS.org

Complications in hair restoration don't occur very often, but when they do, it gives me a reason to educate myself. One such complication occurred in a patient undergoing an FUE procedure a few weeks ago. The problem he developed was intra- and post-operative hiccups. Although I was aware of this side effect with surgery, and knew that it was thought to be a side effect of drugs, I wasn't sure about exactly what the mechanism was that was occurring. I must say that after some investigation I am not much the wiser.

The case itself was very straightforward: 2,500 grafts over two days in a man in his late 30s with no medical problems and on no medications. The patient was pre-medicated with 10mg diazepam and 35mg prednisolone orally. Intra-operatively drugs used included lidocaine 1%, bupivacaine 0.5%, and triamcinolone with epinephrine 1:100,000 in a tumescent solution. Vital signs were normal throughout. It was noted on the first day at the patient's lunch break that he had intermittent hiccups. These were not distressing to him and continued after his food and after drinking water. At the end of day 1, the hiccups still persisted intermittently and on returning the next morning were still occasionally present. The second day progressed in much the same manner as the first day. On the third day at check-up hiccups were still present; however, the patient reported no problems with sleeping. As the patient was not in any distress and was due to fly overseas to his home country, I decided not to treat with medication but to wait to see if they resolved spontaneously.

Persistent hiccups are described as lasting 48 hours or more and intractable as lasting more than 1 month. A hiccup is an involuntary contraction (myoclonic jerk) of the diaphragm that may repeat several times per minute. The medical term is synchronous diaphragmatic flutter or singultus, which is Latin for the act of catching one's breath while sobbing.[1] A reflex arc causes a strong contraction of the diaphragm followed about 0.25 seconds later by closure of the vocal cords, which results in the classic "hic" sound. At the same time, the normal peristalsis of the esophagus is suppressed.

On looking at the hair transplant literature, there was not much information on the cause and treatment of this condition as it relates to hair transplant surgery. It is reported as being a side effect most commonly of diazepam and associated occasionally with irritation of the vagus nerve in strip surgery.[2] In the past, we have had a very rare occasion where a patient has developed hiccups during the course of the procedure, but this has always been a short-lived event with no specific treatment required. A case report of herpes zoster, as described by Cotterill, also had hiccups as a complication.[3]

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William H. Reed, MD *La Jolla, California, USA* editors@ISHRS.org

Resolved: There is an increased risk of overharvest of the donor from FUE relative to a strip harvest in a young person showing evidence of developing more advanced stages (Norwood IV+) of balding.

Okay, now that I have the hair standing up and blood pressure elevated on some and others at least reading beyond the first sentence, let me state my position that rarely are issues such as this black and white. However, from the donor perspective, FUE, as with any recent evolutionary process, evolves new risks in addition to the evolution of its positives. I propose that the donor is one such potential risk where the nuances and management of over-depletion need clarification, and the sooner the better.

If we are going to learn from the Fathers of our field, we should pursue the stated goals of the ISHRS—to educate, communicate, and interrelate—in order to avoid the mistakes they made of overharvesting the donor with their plugs with, among other things, resultant unsightly donor depletion. With the increasing automation of FUE, the practitioner can exert a power of extraction that outruns the learning curve of his exercise of judgment.

It appears to me that a strip excision, and the associated avoidance of over-depletion of the donor, is easier to teach than is the over-depletion of the donor with FUE. With strip excision, keep the strip narrow for reasonable closure tension and the scar is going to be reasonably acceptable. If not, then FUE can soften the contrast of the scar with the surrounding donor. With FUE, however, how do those experienced in the technique teach the variables involved in overharvest of the donor in order to avoid over-depletion? If the young patient needs only a small number of grafts, then donor depletion is not a concern…at least over the short term. But what if this young patient needs more grafts over the next decade before the "safe zone" can be confidently ascertained? Do we resort to doing a strip excision during this period or do we generate a depleted "safe zone"? The "safe zone" has to be defined conservatively due to the patient's age and undeterminable degree of future balding. It seems the FUE practitioner has to either ignore the "safe zone" or risk generating a wide band of depletion within the "safe zone," which is ringed above and below by high density "unsafe" donor. How do those experienced in FUE deal with this situation? How do they teach us how to deal with the multiple variables that are much more important with FUE than with strip excision due to the wide zone of depletion versus the strip scar? These variables include donor density, fiber diameter, curl, color contrast of donor hair to skin/scar, and the possibility that the patient may want to style his hair differently in the future in a way that is incompatible with the wide zone of low density generated by a given degree of donor depletion.

I've asked half a dozen of the practitioners who have contributed mightily to our specialty to address this issue. I apologize for not asking some of you who are equally as qualified but ask you to please write a letter to the editor to share your knowledge and experience regarding this issue. I asked Russell Knudsen to comment and edit the responses in his "Controversies" column and am indebted to all of you for helping move our field forward with forethought and utmost concern for our patients by participating in our efforts to educate, communicate, and interrelate.◆

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Submission deadlines:
June 5 for July/August 2013 issue
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Farjo Message

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In the wider literature, causes of hiccups have been attributed to several things: phrenic/vagus nerve stimulation, drugs, metabolic conditions, electrolyte imbalance, direct stimulation /irritation of the diaphragm (e.g., in intra-abdominal surgery), infection, CNS disorders, arrhythmias, coughing, and alcohol.[1] The incidence in hair transplantation is very low having been described in one case series as 0.2%.[4] In the general population, incidence is described as equal amongst the sexes but intractable hiccups are more common in men for unknown reasons.[1]

Treatment of choice for sustained hiccupping is chlorpromazine, a potent anti-psychotic that also has anti-emetic properties. Side effects of chlorpromazine include sedation and for this reason I chose to wait and not treat this patient as he was flying overseas. It was not an ideal situation to be sending the patient on a plane under the influence of a strong sedative and carrying anti-psychotic drugs into another country. Instead I gave the patient the name of the drug and told him to contact his own physician if the hiccups hadn't resolved in a couple of days. Fortunately, at follow-up after 4 days, the patient reported resolution without treatment.

References

1. Wilkes, G. www.emedicine.medscape.com/article/775746-overview. 2 August 2007.
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3. Cotterill, P. A case of shingles (herpes zoster) post hair transplant. *Hair Transplant Forum Int'l.* 2012; 22(6):223.
4. Salanitri, S. et al., Surgical complications in hair transplantation: a series of 533 procedures. *Aesthet Surg J.* 2009(Jan-Feb); 29(1):72-76.◆