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INTERNATIONAL SOCIETY OF ISHRS HAIR RESTORATION SURGERY

forum

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The "One-Pass Hair Transplant"—A Six-Year Perspective

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Introduction

Most traditional hair transplant techniques require two to four sessions into the same, initially bald, recipient area to provide sufficient hair density over a large enough area to be cosmetically acceptable to the majority of patients. The need to return for these multiple sessions leads to multiple times off work, multiple cosmetic recovery times, more pre-operative anxiety, and more post-operative discomfort for the patient.

Wouldn't it be more convenient for the patient if an adequate density of transplanted hair could be achieved over a (traditionally-sized) targeted recipient area in just one session of hair transplantation? Hence, the rationale for the "one-pass hair transplant." This article will summarize its evolution, its benefits, and how the author has overcome myriad technical difficulties encountered during the development of this technique.

The Concept

The author will never forget hearing a question posed to a panel of experts at a hair transplant convention in Rio de Janeiro in 1992. The question was: "Which of the four (standard graft) sessions required to complete a hair transplant grows the best?" What was amazing was the confidence of the delivery of an emphatic and absolute answer that, without any thought or hesitation, came straight from the mouth of Dr. Martin Unger: "The first. The first session always grows the best." This revelation was the inspiration to devise a method in which the "first session" into an area would be the only session required.

Wouldn't it be more convenient for the patient if an adequate density of transplanted hair could be achieved over a (traditionally-sized) targeted recipient area in just one session of hair transplantation?

The Hypothesis of Less Scarring Leading to Better Growth

One can hypothesize that scarring, or "microscarring" in the case of follicular

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Feature Articles

Happy 10th Anniversary ISHRS!

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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.

President's Message

Bobby L. Limmer, MD
San Antonio, Texas

This is my last *Forum* message as President of the ISHRS. The opportunity to serve you has been both a joy and a privilege, and I want to thank each of you and the administrative staff for all the help you have given. After the Chicago meeting, the office of Presidency will transfer to Dr. Robert Haber, who I am quite confident will lead this Society in a capable manner. Dr. Haber has been a strong advocate of leadership based upon what is best for the majority membership of this Society. Dr. Tony Mangubat, who will continue to serve as Treasurer in 2003, has been very instrumental in establishing and maintaining the Website as well as gaining industry support. Dr. Mario Marzola completes his term as Secretary, and the offices of Vice President and Secretary will be elected at the meeting. Nominations for office may come from the Board of Governors and from the floor of the general business meeting. In addition, Victoria Ceh returns as executive director and the Society is blessed to have her back.

I am hoping to see each of you at the ISHRS 10th Annual Meeting in Chicago this October 10–13. We offer on-site registration and this meeting will provide a great forum in which to again see or meet for the first time many of your colleagues. Among the greatest strengths of this Society is the fact that we are small enough to know each other. Each of us has something to offer by being an active member.

I look forward to seeing you there!✧

Bobby L. Limmer, MD

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

Please send submissions via a 3½" disk or e-mail, double space and use a 12 point type size. 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. We prefer e-mail submissions with the appropriate attachments. *Send to:*

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Submission deadlines: November/December, October 10; January/February, December 10.

Co-Editors' Messages

Michael L. Beehner, MD
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On one of the Internet discussion groups where physicians are invited to respond to patients' inquiries, Bobby Limmer, MD, and I recently got involved in a little back and forth discussion as to whether or not hair transplantation is an *art*—or, put another way: Is the hair transplant surgeon an *artist*? I expressed my strong opinion that the surgeon is indeed an artist. In "Words of Wisdom for Newcomers" (p. 187), I note that Dr. Limmer again reiterates his opinion that hair transplantation isn't art ("There is no art."), but his next two sentences seem to somewhat contradict the opening statement. If we were mechanics on an industrial assembly line, following each step just thus and so, making each of our automobiles or widgets the exact same, then I would agree with him that we are not artists, but rather, good faithful technicians.

But any doctor who has been in practice for a while and seen hundreds of completed transplant patients—both of his own making and by the hands of others—knows that all surgeons do not have the same knack for producing natural, aesthetic results. Some "have it," and others don't. I agree totally with Bobby that a good hair surgeon must know the "science" of our specialty upside down and sideways, but, because each patient is uniquely different from every other one, I think the combining of the countless factors that go into each graft's contribution to that patient's eventual appearance can be described by no better word than "art." In my view, when one creates something that is "art," there must be an intimate sense and knowledge of what previous efforts with that same particular combination of tools and raw materials produced in past instances. Each time we begin transplanting a new patient, we are presented with a new set of "brushes, canvas, and paints," if you will, with which to work. Somewhere between shaking the patient's hand at the first greeting and making the initial recipient sites on that patient's head, the surgeon must factor together all of these myriad variables—the color, curl, and texture of the hair; the density of the donor area; the percentage breakdown of 1-, 2-, and 3-hair FUs; the shape and size of the patient's head and alopecic area; the relative positions of the fringes and temple hair; the likely future of MBP in this patient; the patient's unique wishes for a final result; the patient's

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William M. Parsley, MD
Louisville, Kentucky

One of the most fascinating facets of hair restoration is the smorgasbord of choices before us. The first choice is whether or not is it advisable to operate on a given patient, to treat with medications, neither, or both. If you decide surgery is advisable, do you want to treat with transplants, scalp reduction, or even flaps? Or artificial fibers? If you decide on transplants, do you want to use round grafts into holes, round grafts into incisions, slot grafts, slit grafts, mini-/micrografts, or follicular unit grafts?

From where do you want to take the donor tissue (considering the future needs)? If you think you might need the lower occipital area to complete the transplant, do you take it early when there is the least tension, or do you wait and take it last—thinking you possibly might not need it at all? Do you want to use only the occipital area as donor or do you consider parietal and temporal areas as potential donor sites? Do you plan to use a single blade or a multi-blade? Or do you plan to use punch excisions? How wide can you make the strip? Do you remove the old scar in future sessions or go into a virgin area? Is the patient prone to stretched scars? On closing, do you use deep sutures? What type? Do you close the skin with staples or suture? Or glue? If suture, what type—and do you use a simple running, interlocking, or subcuticular? Absorbable or non-absorbable cutaneous sutures?

In the recipient area, do you make the sites with round punch excisions, slot punches, flat blades, or needles? If a flat blade is used, what shape is best? Should you use a 15°, 22°, 45°, limited depth, curved blade, or pointed blade, or make your own by cutting razor blades? Should you create your sites in advance or use stick and place? If stick and place, should you do it solo or have an assistant? Should you use tumescence? If using a blade or needle, do you plan to orient the sites sagitally (parallel) or coronally (perpendicular)? Does it make a difference? If so, what is the difference? Do you divide or group follicular units in some circumstances?

How about the hairline design and transition zone? Are you going to transplant the vertex or temples? How about parietal humps?

These are only a small percentage of the decisions one must make on each and every transplant. The truth is that the most important parameter is results. All these methods mentioned above have been successful in the proper hands, with the proper skill, and with proper patient selection.

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Beehner Message

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preferred future styling pattern; the patient's tolerance for any early detectability; and at least a dozen other factors too numerous to name—and, out of all this, he must formulate and execute a plan in which each hair and graft placed on the scalp results in a head of hair that appears "natural." As with many other art forms, a *visual* image is created that is unique. All of us would agree that producing good hair transplant results also includes *not doing* certain things, among which are placing the grafts too perpendicular to the skin, letting the epidermis of the graft "dunk" beneath the skin (resulting in "pitting"), drawing a front hairline with an unnatural contour or height, etc. Perhaps one could even say that the meticulous avoidance and prevention of these sins is also included in the "art" of transplanting.

For the sake of argument and setting priorities, I would select the following five aspects of transplanting (my "big five"), which, if done consistently well, in my opinion result in wonderful, *artistic* heads of hair:

1. Proper angling of grafts (usually at a fairly acute angle)
2. Avoidance of "pitting" or compression, so that the *exit point* of each hair looks very natural
3. Proper hairline contour, height, and "feathering" (I think that the gently flared hairline works best on 95% of heads.)
4. Creating soft, imperceptible "gradients" of hair density "from the outside in" at all borders—that is, the avoidance of a totally homogenous end-product. Knowing which types of grafts will do this (and *where* to put them) for each individual patient is, in my opinion, the single most important *artistic* talent of an excellent hair surgeon.
5. Not "screwing up" the vertex (crown). In most cases, this means probably not transplanting this area. Certainly, for most patients, it includes not putting scars there, not placing large detectable grafts there, and not distorting its contour and shape.

If the above comments stir up any reaction or comments from the readership, Bill and I would be happy to print them as "Letters to the Editors," so please feel free to fire back with your own opinion.

ABHRS to Offer Certificate

The American Board of Hair Restoration Surgery is presently gearing up to offer the Certificate of Added Qualification (CAQ) in hair restoration surgery to all eligible hair surgeons, and is also determining the steps that will be necessary for surgeons outside North America to sit for the exams and become Diplomates of the new International Board of Hair Restoration Surgery, which will be a subsidiary of the ABHRS. Hopefully, most of these details will have been worked out and be available at the Chicago meeting. There are a few obstacles and logistics that still have to be worked out, but the final goal is two-fold: one of trying to set standards of excellence that all hair surgeons will aspire to, which in turn will satisfy the regulatory forces in our various countries and also reassure our patients that we, as Diplomates or holders of the CAQ, are well grounded in our science and have demonstrated our commitment to providing a quality service; and second, one of the ABHRS trying to be as *inclusive* as possible, with the ultimate goal of all serious hair surgeons someday being Diplomates of either the ABHRS or IBHRS. We hope that the groundwork set in place in the next couple of years will be fruitful for years to come, and that a spirit of good will and trust will prevail among all hair surgeons, whatever their country or affiliation with various other professional groups.

I'd like to close by sharing the words that are on a white refrigerator magnet that was given to me as a gift by a visiting plastic surgeon. The words, to my mind, represent the wishes and hopes of every hair surgeon for every hair that he or she touches:

Every blade of grass has its angel that bends over it and whispers, "grow, grow."

—The Talmud✧

Michael L. Beehner, MD

were still instructed to not eat after midnight. The study suggested that preoperative dehydration may actually increase postoperative discomfort and vomiting and recommended following the updated guidelines.

9. Sending scrubs out to be laundered.

Many healthcare providers believe that home-laundering scrubs increase the risk that infectious diseases may be brought into the home and contamination will be brought into the operating room. The AORN has stated the scrubs should be laundered by the healthcare facility. The CDC refuses to comment one way or the other, "because of the absence of well-controlled studies." And OSHA recently released guidelines that stated that employees may launder soiled scrubs at home, but the health care facility must launder contaminated attire. According to OSHA, soiling occurs for perspiration, body oils, or contact with items handled by the health care worker. Contamination involves contact with "blood or other potentially infectious materials."

Ms. Reecer's facility has laundered their scrubs for many years, as does Ms. Burden's. "Our nursing staff washes their own scrubs at home—unless there is visible contamination. Then we would treat them like our own contaminated linens and send them to our laundry service," she says. "We got resistance at first. When we originally made this change, some nurses at one of the other ASC sites in the health system were so up in arms that they worked to get the surgeons to back them up against the change. When an orthopedic surgeon raised the challenge to the manager, she told him that if he trusted the nurses to keep his cases sterile in the room, why would he not trust them not to pump gas in their scrubs on the way to work? He didn't have an answer."

If you decide to allow your staff to launder their scrubs at home, OSHA guidelines recommend having scrubs available for surgeons and staff members whose scrubs may become grossly contaminated.

When determining what sacred cows to banish from your facility, it's still most important to consider what will work best for your staff and your patients and what feels most comfortable to you.✧

Parsley Message

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So what are the important considerations? My opinion is that certain principles are still being violated and continue to hurt our field. I have listed what I consider to be five of the most important continuing problems, starting with the most important:

1. *Underestimating future loss.* Why are we not learning the lesson? Even follicular unit grafting will not bail us out here. A 20-year-old never, ever has stable loss. Neither does a 30-, 40-, or 50-year-old. Please let us stop deluding ourselves. Transplanting young patients is often a ticking time bomb for disaster and embarrassment later in life.
2. *Not understanding the design for a proper frontal hairline on a male.* It does not flare out and cut across the fronto-temporal angle like a woman's hairline. I have patients ask me every week to cut across this angle. It is OK for them to not understand, but not for the doctor.
3. *Transplanting the vertex too early and not leaving enough hair for the frontal and midscalp later in life.* It is said that hair loss in the fontal scalp "hurts your appearance," but hair loss over the vertex just "hurts your feelings." Don't sacrifice the frontal scalp. A good, but loose, rule is to not transplant posterior to the vertex transition zone until the patient is 45 years of age.
4. *Starting transplantation without proper training.* This is a real thorn in our side. Many doctors with little preparation have ventured into hair restoration surgery only to find that it is harder than it looks. These patients are often hard to repair and become bitter toward all of us. There are presently no laws to prevent even the most unprepared doctors from operating on patients. The main thing we can do is stress to any new surgeon to sacrifice and put in a lot of study and effort before starting. We all remember those doctors that gave each of us help when we were starting. Some guidance and help from those experienced in our field can certainly reduce this problem.
5. *The feeling that medical therapy is the enemy of transplant surgeons.* Nothing is further from the truth. These medicines have the potential to bolster existing and grafted hair and provide much greater patient satisfaction.

It is good to see the variety of techniques used but there is a limit. Certain rules do not need to be continually re-learned.✧

William M. Parsley, MD