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INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

forum

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A One-Year Study of Using Exclusively "Follicular Grouping Grafts" in Specific Areas to Increase Hair Density and Volume during FUT

Arthur Tykocinski, MD *São Paulo, Brazil*

What every hair transplant surgeon wants is to produce a result that satisfies the patient. Producing a satisfied patient requires meeting his/her goals of both naturalness and density. Today, a patient wants to accomplish as much as possible with each session. No one doubts that we can produce natural results with the exclusive use of FUGs (follicular unit grafts);[1,2] however, meeting the patient's expectation of density after a single session is a more difficult task to accomplish, especially if we only use FUGs at 20–30 FU/cm^2. To create greater density, we have traditionally had one of the following options:

1. *Use larger grafts such as minigrafts*[3] *to increase hair density.* However, in the initial session, we are still limited in the hair density we can create because we need to use larger incisions placed farther apart. In addition, minigrafts have the potential to be more noticeable than FUGs after the first session.
2. *Use a greater degree of dense packing.* We ultimately need a density of 40 FU/cm^2, or more, to satisfy the average patient's expectation of hair density. Most physicians place FUGs at densities averaging 25 FU/cm^2. Higher densities are possible, but this is a process that is both more tiring and technically difficult. In addition, dense packing at a greater density than 30 FU/cm^2 is believed to potentially have lower survival rates. This is especially true in the central area, in older patients, and in smokers. In extreme cases, tissue necrosis can occur.[4,5]
3. *Repeating multiple sessions.* The problem with multiple sessions is that patients would obviously like to have more density, as soon as possible.

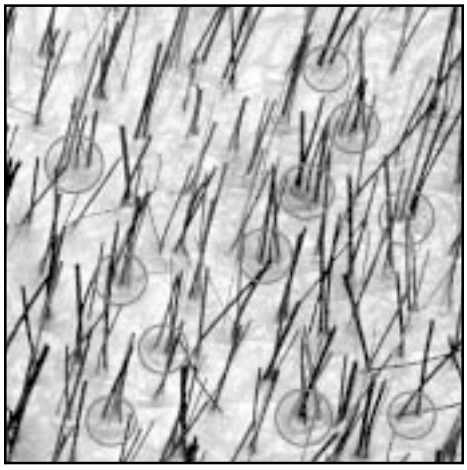

Figure 1. Donor area showing a population of FGs with 4–6 hairs (circles).

The "Missing Link"

In the evolution of hair restoration,

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Regular Features

Feature Articles

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President: Robert S. Haber, MD
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@attbi.com
Advertising Sales: Cheryl Duckler, 847-444-0489; cduckler@attbi.com

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

Robert S. Haber, MD
Mayfield Heights, Ohio

As our Society matures, it will be necessary for it to take on greater responsibilities in the realm of education. Before the ISHRS, the teaching of the techniques and principles of hair restoration surgery took place more informally, in doctors' offices and in gatherings without a global vision. The early meetings of the ISHRS were relatively informal as well, and we learned as we went along.

Things are different now. We have a more organized structure, and more of our activities have been formalized. The loss of spontaneity has been compensated by an extraordinary increase in the quality and quantity of the educational experience. And where we were once not accredited at all, we are now accredited by the American Academy of Dermatology.

Our next phase of educational maturity will involve achieving independent accreditation status, so that we can bestow CME credits on all physician members, regardless of primary training. This is not an easy task, and will require us to adhere to standards that many organizations cannot achieve. It will require us to expect the highest quality research and presentations, and the studious avoidance of profit as a motive for any educational endeavors.

Of course, these are standards we already try to reach. We simply must fully and formally adopt them, and demonstrate our success. Reaching independent accreditation status is no small goal for it will identify our Society as a serious educational organization, a status we are still not granted by many of our colleagues in other fields.

This status will also require us to be more selective and demanding in determining who can be affiliated with the ISHRS in sponsored events, and we will set the standard of quality that will be useful not only to hair restoration research and training, but for unrelated fields that may look to us for guidance in our maturity.

These advances would be impossible if not for the overwhelming acceptance of the value of "hard science" in our meetings and presentations. Those of us who attend meetings of other societies will recognize that this is uncommon. At each Annual Meeting, our members have elevated the quality of the presentations, and raised the bar for those who have followed. I expect this to continue and, as it does, we will find ourselves being more admired by colleagues who used to look upon us with scorn.

If you don't believe me, come to New York and be dazzled!✧

Bob Haber, 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:*

William M. Parsley, MD
310 East Broadway, Suite 100
Louisville, Kentucky 40202-1745

E-mail: bparsley@bellsouth.net

Submission deadlines:
September/October, August 5;
November/December, October 10.

Co-Editors' Messages

William M. Parsley, MD
Louisville, Kentucky

We owe a lot to Dr. Stough. He has been a true pioneer in education. He had the foresight to see the power of open communication and exchange at a time when very little was being done. No doubt his efforts have sped the progress of our field and made us one of the most robust cosmetic subspecialties. People from all over the world have come to a little town in Arkansas to improve their knowledge and skills in hair restoration, and to make lasting friendships. Many feel a doctor's education in hair restoration is not complete until he or she has come to Hot Springs. No, I am not talking about Dr. Dow Stough, even though it would all be true. I am talking about Dr. Bluford Stough, Dow's father.

I got my start in transplantation by visiting Dr. Bluford Stough in the winter of 1974. His enthusiasm was infectious to me, as I am sure it was to others who visited him. Dr. Stough has made an impact on our field that few truly appreciate. He was one of the founders of the American Society for Dermatologic Surgery and was the third president. Somewhere around 1975, he started putting together independent meetings devoted solely to hair restoration. Up until that time, hair restoration consisted of a lecture or two tacked onto a larger meeting, getting lost in the crowd. His meetings were small and were limited to 50–60 participants, all of whom were very enthusiastic, and many of whom are today's leaders. They were a success right from the start, and he often had to turn away doctors if they did not sign up soon enough. Dr. Jay Barnett came from New York, Dr. Richard Shiell from Australia, Dr. Walter Unger from Canada, Dr. Sam Ayers from Los Angeles, etc. Hot Springs is not the easiest travel destination; yet they came. Those of us who haven't put together a meeting can't possibly imagine the effort required. The pay is not too good either. We owe Dr. Stough and all the early educators a great debt. Plans are being put together to try to get some of the earliest educational pioneers to New York. If it can be accomplished, be sure to meet these doctors on whose shoulders we stand and say "thank you."

Last month, I attended the annual Bosley Medical meeting in Los Angeles in hopes of exchanging thoughts and techniques. Up until now, it has been a totally closed shop. Even though it is still essentially the Bosley Medical Group, Dr. Ken Washenik is the new

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Michael L. Beehner, MD
Saratoga Springs, New York

Two of the most common questions I hear from patients are: "*Are you doing anything different now?*" (usually this comes from a patient who has had at least one procedure a year or more ago) and "*Is there anything new around the corner?*"

For several years, I recall going to 2–3 meetings a year and feeling like I was hearing the same lectures over and over—as if nothing was really changing. I found the best way to put that myth to rest was to see a return patient, who I had transplanted just 2–3 years earlier, and I could note how different we approached his transplant session. Take the simple matter of the number of micrografts/FUs placed in the front hairline zone per session. We went from 25–30 in 1989, to 100–130 in the early 90s, 200–230 from 1997–2001, and now consistently place 300–360 FUs. Then there's the simple matter of graft numbers. Our average case now is 1,100 grafts, and just one year ago it was 850–900.

Other changes? The biggest, at least in our practice and I would assume in most others, is simply the huge paradigm shift over time as to what's *possible* and what is *safe* to perform at one sitting on a patient's head. The instruments we use to make the recipient sites are certainly more refined (19, 18, & 17g solid-core needles) and skinnier than in years past. My staff's skills in placing grafts and in cutting slim grafts also has improved immeasurably with my nagging and prodding.

Another big change for me has occurred in my opinion of combining finasteride therapy with the transplant surgery. I used to pooh-pooh the notion of placing HT patients on medical therapy. Then I saw a few startling results of combined therapy in some colleagues' patients. I also noted that some of my transplanted patients, in whom I thought I had added quite a bit of hair, after a few years seemed to have only a "trade-off" in total hair mass, as the gains from the transplant were offset by the progression of MPB. I now realize that using both modalities results in an *additive* effect of two positives, rather than in simply ending up with the *difference* between the transplants minus the ravages of MPB. When patients ask me if they will have to take finasteride for the rest of their lives, I usually reply: "Probably not; just until the next wonderful thing comes along." And when and what that will be, I have no idea! I personally think the hormone modulation route has been taken as far as it can go and am skeptical that hair cloning will ever be practical. My hunch is that the chief hope for a non-surgical future answer to hair loss is to somehow alter the genetic programming of the follicles.

Another valuable addition to my transplanting "toolbox" has been

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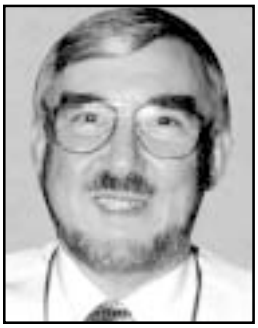
Notes from the Editor Emeritus



Richard C. Shiell, MBBS
Melbourne, Australia

From Recent *Forums*

The work from the Moser Clinic on the prevention of apoptosis in hair follicles may have far-reaching consequences for us all and we await further confirmation of their important studies.

Some independent research by Drs. Jerry Shapiro and Vera Price on the value of 5% minoxidil caught my eye. In these days of a pill for everything, it is a welcome reminder that there is still a place for topical medication if begun early and used conscientiously. Unfortunately, all experienced hair physicians are aware that the patient compliance rate with minoxidil is far from satisfactory. Much of the reported "poor results" that we record in our notes arise from the lotion being applied a few times a week instead of twice a day as directed. Part of the problem is that the average young patient claims to be "too busy" to remember to apply the lotion twice daily. The underlying problem is that the lotion is a nuisance to apply and the slight residue alters the natural lustre of the patient's hair. As improvement takes many months to occur, the patient rapidly loses enthusiasm and the regularity of application falls off.

I enjoyed Dr. Bernard Nusbaum's article "The Great Imitator" (Vol. 13, No. 2; March/April 2003) in which he warned us of the ability of lichen planopilaris and diffuse alopecia areata to mimic androgenetic alopecia.

I had an interesting case last year when a 78-year-old white, male patient of mine returned complaining of the recent and almost total loss of frontal grafts that I had inserted 31 years previously. Biopsy showed perifollicular fibrosis with lichenoid lymphocytic inflammation, and a diagnosis of frontal fibrosing alopecia was made. This condition, a variant of lichen planopilaris, was first described only a decade ago, and this is only the second case recorded in a male. I am sure that many other cases will turn up in elderly males once doctors are aware of the possibility and do not blindly attribute all frontal hair loss to male pattern baldness.

I was also fascinated to read in the March *Forum* that the laser was still alive and well in many HT offices. Drs. Nemeth, Riggs, and Neidel all wrote glowingly of their experiences with the Erbium laser over the past several years. With the use of the Sapphire tip, it appears that the angle and spacing of laser slits can mimic that of cold steel but with the added advantage of minute bald tissue ablation. All three doctors claim that, with experience, there is no problem with second and third sessions in the same area.

For those of you who already have an Erbium laser, this seems to be a valid additional use for the machine. Basic cost and continuing maintenance of lasers is high, however, and I doubt if it will find a place in the average HT office where a 50-cent needle or a $10 punch still fills the role very well.

Dr. Alan Feller's second contribution to this same issue (page 302) was a delight to read. If his hair transplants are as good as his penmanship, then the good people of Great Neck, New York, have a living treasure on their doorstep.

Membership Directory

I always enjoy checking the ISHRS *Membership Directory* and seeing whether our numbers are up or down. Readers may be interested to know that (as of the printing of the *Directory*) total physician membership of the ISHRS has increased by 2% to 612 since the last *Membership Directory,* which was published 12 months ago. Membership has risen 5% within the USA but dropped off in Europe with French, German, Italian, and Spanish membership all falling around 10% or more. This may be a credit to the ESHRS, which has gained in importance on the Continent in recent years.

As in 2002, the USA, Canada, and South Korea remain the major players with 332, 54, and 28 members, respectively. Mexico has risen to fourth place where, with 16 members, it joins with Brazil.

We still have representatives from 49 countries, having gained members from Bahrain, Russia, United Arab Emirates, and the Philippines, but we've lost our members from China, South Africa, Venezuela, and Yugoslavia.

The Surgical Assistants membership at 108 continues to decline, with an overall drop of 5% this year, although the U.S. membership remains steady at 81. I think the ISHRS Board should review the charges for Surgical Assistants and see if membership numbers can be boosted. At US $100 this may be too high for assistants in many countries.

Surgical Assistants Corner

Shanee Courtney, RN, is doing a great job as Editor of Surgical Assistants Corner, and thanks to those of you who have been sending contributions. Many assistants have vast experience. My own assistants, Pamela and Loreen, have been with me since 1976, but it is difficult to convince them that they have "pearls" to pass on to the younger generation. I am sure that many of you feel the same, so perhaps it is up to us doctor-employers to assist in the creative process so that this wonderful "trapped" knowledge can be released for all to read.✧

Richard Shiell, MBBS