

## Trichophytic Closure of the Donor Area

Mario Marzola, MBBS *Norwood, Australia*

### COLUMNS

- 114 President's Message
- 115 Co-Editors' Messages
- 117 Notes from the Editor  
Emeritus
- 129 Scalp Dermatology
- 131 Cyberspace Chat
- 135 Surgeon of the Month
- 136 Pioneer of the Month
- 137 Pearls of Wisdom
- 147 Classified Ads

### FEATUREARTICLES

- 119 Donor Harvesting with  
Invisible Scars
- 121 Polarized Magnification  
for Creating Recipient  
Sites
- 122 Scalp Elasticity Scale
- 124 Roundtable Discussion:  
Donor Closure
- 138 10<sup>th</sup> Annual Meeting of the  
Italian Society for Hair  
Restoration
- 140 8<sup>th</sup> Annual Meeting of the  
European Society for Hair  
Restoration Surgery
- 141 11<sup>th</sup> Annual Meeting of the  
European Hair Research  
Society

With due care and attention to closing the edges of the donor wound accurately, we usually end up with a fine linear scar 1–2mm in width. Sometimes it is a little larger and rarely, when there is a connective tissue disorder or the edges are closed roughly and with too much tension, it is much larger. Today's patients' expectations as well as short hair fashions are driving us to produce scars that are as invisible as possible. There is less potential benefit of follicular unit extraction (FUE) if we can consistently produce scars that are not visible, even with short hair.

Trichophytic donor closure is a neat and easy way of improving our donor scars. It is a technique borrowed from the days of transposition flap hairlines where the front 1–2mm of the flap was de-epithelialised so a few hairs would grow up through the ensuing scar (Figure 1). At the 1999 ISHRS Annual Meeting in San Francisco, our Australian colleague Dr. Simon Rosenbaum presented a technique of closing the donor wound where the tip of the upper edge was cut off before closure (i.e., a trichophytic closure as in the flap hairline). Having used this technique frequently since then, and almost exclusively during the past four years, I have witnessed a consistent improvement in my scars.

You may have noticed in closing so many donor areas that the upper or superior edge is an acute angle, while the lower or inferior edge is an obtuse angle, when the incisions are made parallel to the hair shafts. It is easy, therefore, just to snip off one or two millimeters of that top edge, thereby de-epithelialising one or two follicular units (Figure 2). When the edges are closed, some burying of these de-epithelialised units happens, but I have found that their complete burial is not necessary to produce our "invisible scar."



Figure 2. Top edge being trimmed off, de-epithelialising 1–2 follicular units.

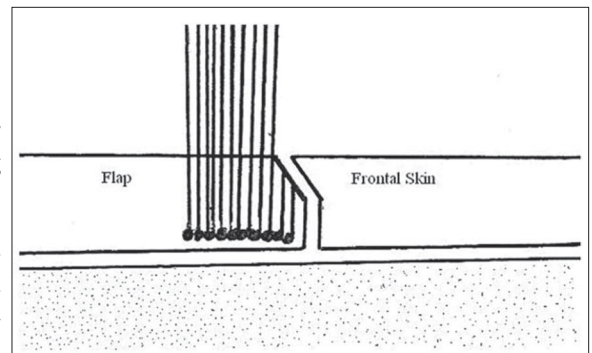


Figure 1. Trichophytic front hairline of transposition flap.

Two beneficial aspects seem to occur in the healing process. First, some of these de-epithelialised follicular units will grow up through the ensuing scar, dispersing its linearity. Second, these follicular units, and maybe a few more around them, grow out at a steeper angle across the scar, again aiding its camouflage.

To try to compare apples with apples, I conducted a trial early last year where 26 consecutive patients had one side closed trichophytically (i.e., with the top edge removed) and the other side closed non-trichophytically (i.e., with the top edge left intact) (see Table 1). My practice is ideally suited to this type of trial as all donor strips are removed in two pieces, one early in the morning and one a few hours later. After 13 cases, the study sides were switched.

continued on page 116

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**Hair Transplant Forum International**  
Volume 15, Number 4

*Hair Transplant Forum International* is published bi-monthly by the International Society of Hair Restoration Surgery, 13 South 2nd Street, Geneva, IL 60134. First class postage paid at Chicago, IL and additional mailing offices. POSTMASTER: Send address changes to *Hair Transplant Forum International*, International Society of Hair Restoration Surgery, 13 South 2nd Street, Geneva, IL 60134. Telephone: 630-262-5399, U.S. Domestic Toll Free: 800-444-2737; Fax: 630-262-1520.

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# President's Message

## E. Antonio Mangubat, MD *Seattle, Washington*

It has been an honor and a privilege to have served you over the past year.

Together we have made so many strides toward bringing our Society more into the mainstream of medicine, and I assure you we will continue to press forward. With this momentum, I expect that over the next year, the ISHRS:



E. Antonio Mangubat, MD

1. Will establish Hair Restoration Surgery (HRS) as a specialty.
  - a. Our Core curriculum for HRS has been accepted for publication.
  - b. The ISHRS has applied to and expects to be accepted by the American Medical Association (AMA) Specialty and Service Society (the largest caucus in the AMA House of Delegates), bringing HRS a significant step closer to becoming a recognized medical specialty.
2. Will successfully undergo accreditation by the Accreditation Council for Continuing Medical Education (ACCME).
3. Will develop formal HRS education for physicians and assistants.
4. Will establish a Hair Foundation with the purpose of raising public awareness of how far we have advanced the art and science of hair restoration, promoting the specialty of HRS, and increasing the overall importance of hair to the public.

My dreams for the future of the ISHRS are to expand our specialty to include a membership exceeding 2,000 physicians, to hold a voting seat in the AMA House of Delegates, to have HRS recognized as a specialty by mainstream medicine, to have formal HRS training centers for physicians and assistants, and to make HRS as universally accepted as general medicine. These lofty visions are achievable as long as we stand together with common goals.

On a personal note, I must thank my friends and colleagues for their help and support during my years serving on the Board of Governors. Your insight and advice have been instrumental in helping me make decisions in the best interest of the Society.

I would like to recognize the extraordinary contributions of our executive director, Victoria Ceh. She is instrumental in the success of our organization, helping me organize, create, and execute a forward-thinking strategic plan this year, keeping us on track with ACCME accreditation, and monitoring our financial status with extreme acumen, and in general, she personally takes charge of the ISHRS business, ensuring our success now and in the future. We are fortunate to have her on our team.

Again, it has been an honor serving as your president this year, and I look forward to contributing to our future. Our 13<sup>th</sup> Annual Scientific Meeting in Sydney is just around the corner. We are all gathering once again to push the art and science of HRS forward, and I look forward to sharing it with you.

With warmest regards,

*E. Antonio Mangubat, MD*

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# Co-Editors' Messages

Jerry E. Cooley, MD *Charlotte, North Carolina*



Jerry E. Cooley, MD

This issue of the *Forum* focuses on donor harvesting, and in particular, new ways to reduce the appearance of the donor scar. When we're presented with a new technique, how do we really know it's better than our current technique?

We often rely on **personal experience**, of course. But new techniques are often difficult at first, and in our specialty, the results may not be apparent for a very long time. We may prematurely conclude a technique is worthless when it's not (and vice versa). We all tend to resist change and do what's comfortable, for better or worse.

One good reason to adopt a new technique is because we trust the experts or **opinion leaders** who introduced it at a conference or published it in a journal. An interesting study published in the *Archives of Surgery* showed that surgeons who participated in this survey believe that surgical "opinion leaders" do exist and could in fact influence them to change their surgical practices.<sup>1</sup> But, unfortunately, our opinion leaders are human, too, and are often in disagreement with each other, changing their minds, or being proven wrong with the benefit of hindsight. On an amusing note, surgeons responding to the above study could not name any "opinion leaders" locally in their own towns but could only do so at the state or national level!

Robert S. Haber, MD *Cleveland, Ohio*



An issue of the *Forum* devoted to donor closure? While some might feel perplexed at such a project, it in fact makes sense. The "closure" represents the best effort of much of what we do. How we close a speech or lecture, how a novel reaches its closure, how a movie's plot line is brought to a conclusion, all leave us with a lasting impression of what came before.

So it is with the donor closure. At times, if one spends any time reading postings on the various Web sites, it seems that we are judged more based on the appearance of the donor scar than on the growth or design of the transplants themselves. In fact, I believe that hair transplant surgeons have spent more time, effort, and creativity fine-tuning the donor scar than surgeons in any other discipline have spent on the scars associated with other procedures.

In most cosmetic procedures, including rhytidectomy, blepharoplasty, and breast augmentation, scars are either hidden in hair-bearing areas or within skin folds. Patients understand that such scars will be present, and a very small number of patients seek scar correction. Why then do our patients expect perfection? Why are linear scars that are well hidden in a hairy area the cause of such vitriolic anger and public outcry? Or is it just a very vocal minority who see perfection as a reasonable goal? When my very early patients periodically return to me, I often cringe at the stacked scars I used to create, and yet other than a desire for additional density, these patients virtually never have any complaints about these scars. I was clear to them at the outset

Another reason to adopt a new technique is because of a study. In other words, **evidence-based surgery**. It's a great idea but very difficult to implement. In a recent review on the subject, Alam recommends that when testing a new surgical technique against a standard one, at least 50 to 200 subjects should participate to reduce both the chance that a difference is found that doesn't really exist ("type I error") and of reporting no difference when it really does exist ("type II error").<sup>2</sup>

How many of us have the time and resources to perform such studies? Even if enough subjects are studied, all of the variables involved in doing surgery create inevitable biases. Our studies in hair restoration surgery generally lack the power and sample size to be considered valid based on these criteria.

We recently learned that even the best studies, published in well-known, peer-reviewed journals, are subsequently disproved up to a third of the time! Having said this, we should continue to rely on our personal experience, opinion leaders, and studies. But we need to hone our critical thinking skills and keep in mind the inherent limitation of each approach to learning new techniques.

*Jerry Cooley, MD*

1. Young J.M. et al. Role for opinion leaders in promoting evidence-based surgery. *Arch Surg* 2003; 138(7):785-91.
2. Alam M. et al. Power and sample size of therapeutic trials in procedural dermatology: How many patients are enough? *Dermatol Surg* 2005; 31:201-205.

that these scars would be produced, and they therefore accept them.

Apart from the somewhat sullied reputation we have had to endure from these diatribes, the beneficial consequence is that we have redoubled our efforts to create the most cosmetically ideal skin closure possible. Great minds and great surgeons from almost every continent are contributing to the quality of the closure. Follicular unit extraction artificially set the bar quite high with the impossible claim of "scarless" surgery, and yet stimulated a competitive process that requires us to at the very least place a high emphasis on our donor closure technique.

As in each aspect of hair restoration, there are almost as many techniques of donor closure as there are individuals operating, and variations and variables include blunt or sharp dissection, undermining or not, deep sutures or just superficial sutures, absorbable or removable sutures or staples, and virtually every suture material manufactured. Now we are learning about the trichophytic closure and the promise of almost undetectable scars.

Time will give us more answers, so long as we are honest with one another. Showing our best scars from any technique is tempting, but not scientific, and those of us experimenting with new techniques must be scrupulously forthright when we share our newfound results. In closing, I'll suggest that the ultimate goal is to accurately determine the "best" approach and encourage its widespread use. If we are to silence the negative chatter that abounds on the Web, it must be through our actions.

*Bob Haber, MD*

## Trichophytic Closure

continued from front page

### Table 1

#### 26 Patients

Donor strip taken in two pieces.

All closed with continuous 4-0 Nylon. Removed at 7 days.

### Table 2

#### Results

Scar evaluation at 7 months by MM and staff.

13 RHSTricho:	10 better than LHS non-tricho
	2 same
	1 slightly worse
13 LHSTricho:	9 better than RHS non-tricho
	4 slightly worse

The results after seven months proved to me that while trichophytic closure is not a panacea, and we still have aspects to learn, it is by and large significantly better than the non-trichophytic traditional closure in producing a much more camouflaged and, therefore, less visible scar (Table 2 and Figure 3).

We need to think of trichophytic closure as the icing on the cake because we still need to produce as thin a scar as possible in the first place. We cannot expect a few follicular units next to the edge to cover a scar that is 3mm wide or greater.

There are as many questions about producing a good scar as there are surgeons. These include: What is the effect of scalp laxity? Can we take a wider strip safely in loose scalps and, conversely, do we need to take a thinner strip in tight scalps? Does the scalp get tighter with each harvest? Shall we confine our graft numbers to that produced by a donor strip 1 cm wide or less? Is it best to excise the previous scar in subsequent harvests or is it best to go to a new area? If we excise the scar, do we excise the deep part of it down to the fascia or



Figure 3. A. Tricho; B. Non-tricho

do we stay just deep to the follicles? Is it best to undermine if the closure is a little tight, and if so, superiorly or inferiorly? Is it best to tumesce or not? What about cautery? Shall we leave pools of blood in the floor of the wound or leave it dry but cooked with cautery? Shall we suture tightly or loosely? Should we use double-layer closure or single-layer closure? Are staples better than sutures? If sutured, are they removed at 7, 10, or 14 days, and what about dissolving sutures?

The basic principles of good surgical practice apply here as much as in any other area of surgery. Start small, be careful and conservative, treat the tissues with respect, and above all else, "avoid tension."

I recommend this little added manouvre of the trichophytic closure to all practitioners using strip donor harvesting. It is simple, easy to master, and takes little extra time. A DVD of the technique can be downloaded from [www.norwooddaysurgery.com](http://www.norwooddaysurgery.com). ♦

### Table 3

#### Best Scars

- ⇒ Accurate apposition (dermis to dermis)
- ⇒ Avoid tension: long, thin donor strips
- ⇒ Avoid tension: no massive megasessions
- ⇒ Avoid tension: no multiple alopecia reductions
- ⇒ Add trichophytic

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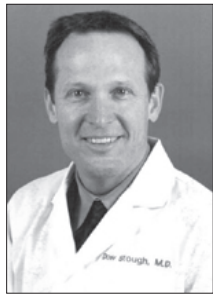


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# Notes from the Editor Emeritus

Dowling B. Stough, IV, MD *Hot Springs, Arkansas*



Dowling B. Stough, IV, MD

## The Paradox of Crown Transplantation

The posterior region of the scalp has numerous designated anatomical terms, such as the crown, the vertex, and the tonsure, all which represent the area commonly referred to by the lay public as “the back of the scalp.” Hair loss in this area can be of considerable consternation for men who experience male pattern hair loss. Many patients with hair loss in this area

seek some type of restoration procedure or medical therapy, or contemplate the use of a hairpiece. Transplant surgeons are sympathetic to these patients’ needs and recognize the immediate benefits of grafting this area. There is a common belief among the lay public that vertex area baldness eventually stops and hair loss is stabilized. The pretense that vertex baldness becomes stagnant is false, and patients need to be educated to this fact. The vertex zone will continually expand over time. The process is unrelenting. The five-year study conducted by Merck on male pattern baldness clearly demonstrated the progressive non-relenting course of male pattern baldness.

Because of the progressive nature of male pattern hair loss, this vertex represents a true paradox to surgeons. Transplanting this area generally satisfies both the patient’s and the surgeon’s short-term goals. However, the long-term cosmesis can be quite a different matter. As hair loss progresses, a halo of baldness will form around the transplanted zone. This appearance has no counterpart in nature and can be quite bizarre. Fortunately, most cases can be restored to a natural appearance with further transplanting. The long-term solutions may be less easily addressed. Limitations of transplantation are imposed due to the requirement of a large percentage of the donor reserves. Once the donor hair reserves become depleted, the halo will continue to progress and the “black hole” or the “bottomless pit” (referencing the fact that this area can consume the entire donor area and still leave the surgeon and patient desiring more grafts) becomes a major concern. Because there is no permanent border, the peripheral border will keep migrating, which will result in an island of central hair. This isolated tuft of transplanted hair can thus become more of a concern than the original bald or thinning state. Lessons of the past have shown that scalp reductions alone will not eliminate this problem.

Taking this into consideration, can the vertex be safely transplanted? If we possessed a crystal ball to aid in determining the extent of hair loss through one’s lifetime, then the vertex area could be transplanted with complete impunity. Currently, we cannot do so. The surgeon must realize the tremendous risk he or she places a patient in when transplanting this area. Dr. Manny Marritt refers to the *overwhelming responsibility* that is imposed upon the transplant surgeon: “As I step back and look at the hairline I have just drawn, I further remind myself that this hairline and the graft dispersement must look natural, not only when he is 35 but also when he is 45, 55..., and 65. That simple ‘office procedure’ has, in reality, just handed me a life sentence of follicular responsibility. The weight of this awareness is not

only humbling, it can be, at times, simply overwhelming.” Dr. Marritt’s comments in this quotation were directed to the anterior hairline, but the sentiments of responsibility are applicable to the crown as well.

## The Safety Net

Transplanting the crown is indeed a decision that cannot be made lightly. The dogma that no vertex should be transplanted should not go unchallenged because there certainly are patients for whom this is not an issue. A 55-year-old with dense terminal hair and a small 6 to 10 centimeter oval area of alopecia on the vertex may indeed be a candidate. But for men under the age of 30, transplanting the vertex should be viewed with extreme skepticism. The ability to utilize medical therapy to stabilize male pattern hair loss has relieved some degree of concern that future hair loss will create a condition without a surgical remedy. However, finasteride is not the ultimate safety net. Even for the patient who is currently tolerating this drug and receiving the benefits of stabilization, there are a number of factors that do not allow medical therapy to be the panacea for vertex transplantation. First, the patient may develop a side effect to finasteride and be forced to withdraw the medication. Second, the patient may also find himself in a situation where he is no longer able to afford the drug. Third, the drug may be recalled due to unforeseen long-term problems. While this last scenario is quite unlikely, the possibility cannot be ignored. Thus, ongoing therapy with finasteride while transplanting the vertex should not be considered risk-free.

It is imperative the transplant surgeon shoulder the risk of vertex transplantation with the patient. He or she should guide the patient to the best decision. The lay public cannot comprehend the eventuality of the progressive nature of hair loss, and therefore, the above arguments often give way to the desire to alleviate the anxiety of the vertex baldness.

## The Dilemma of Guidelines

In an effort to do what is best for the patient, many transplant surgeons feel that it is most important to maintain a good rapport with patients and convince them that any short-term benefit may have detrimental long-term consequences. Some surgeons feel that it may be appropriate to perform a small “conservative” session so that the patient will not go elsewhere and have what could be a potentially injurious procedure. The topic of guidelines continually resurfaces at meetings and discussions among concerned surgeons. Guidelines for vertex transplantation have not been created due to the fact that dogmatic views are seldom accepted in medicine. Published guidelines are difficult to embrace by experienced surgeons who recognize the need for occasional departure. These departures are critical to the practice of medicine and should be embraced and supported. Surgeons are wary of a legal community that has neither the desire nor the ability to recognize exceptions once guidelines have been published. Thus, well-meaning guidelines will work against the good of the whole in that they could be used against all surgeons in all cases of exceptions. It is not this author’s intent to create rigid guidelines with no flexibility. Our field deserves better.

continued on page 118

**Editor Emeritus***continued from page 117***Views of Other Surgeons**

Dr. Richard Shiell, Editor Emeritus of the *Forum*, with over 38 years of experience and thousands of cases, states: "It must always be remembered that the crown can become a bottomless pit into which vast numbers of grafts can be poured for minimal cosmetic benefit. If you want to be 100% secure then don't do the crown area at all. Most of us can live with a little risk, however, and in carefully selected patients of 35 or over, where history and examination show that the risk of massive expansion is small, then the surgeon may agree to graft the crown. The potential risks and contra-indications must be explained to the patient and he must sign to say that he understands these risks. Under these conditions you should have a happy patient and there should be few problems in years to come."

Dr. Bill Parsley lends his scholarly opinion on the subject: "My present 'guideline' is to not transplant the vertex until age 45. This doesn't mean that I will transplant the vertex at that time; only that I postpone my decision until then. A person's appearance is directly related to the facial framing of hair. The vertex has very little cosmetic impact. A balding vertex can cover an area of over 100cm<sup>2</sup> while expanding into normally used donor areas. I have seen many otherwise successful transplants ruined by trying to do too much. My ideal vertex patient is over 50, and has a small bald area with abrupt borders. Also, mature patients who have had their frontal and mid-scalps restored, yet have substantial donor hair remaining, are potential good candidates. I don't try to plant too thickly and mainly use uniform density instead of graded density, which, in my opinion, makes future commitments more difficult. View the vertex as you would sirens on the rocks."

Dr. Bobby Limmer, the father of modern transplantation, related the following: "The most difficult task the consulting physician faces is educating and convincing the hair loss patient that the frontal and mid-scalp restoration constitutes 90% of the value while vertex (crown) restoration produces the other 10%. The youthful patient is often the most difficult to convince as well as the most likely to develop substantial progression of his alopecia. There are no fixed rules, but these principles have served us well over the past 17 years of follicular unit transplantation methodology: 1) The frontal and mid-scalp restoration will be completed first. Only after that will the crown be considered. 2) Medical therapy, combined topical minoxidil and oral finasteride, will be used while the frontal and mid-scalp restoration grows in. 3) In those less than 45 years of age, the crown will not be transplanted. In those in which the crown is transplanted, the goal is to cover the area with a cosmetically acceptable but not maximal density coverage in order to conserve donor hair for the potential future needs."

Will crown area transplantation eventually go the way of scalp reductions? Time will tell. Until then, it is our responsibility to protect our patient's long-term cosmesis.

Primum non nocere

*Dowling B. Stough, IV, MD*

**FURTHER READING**

1. Marritt, Emanuel. The Overwhelming Responsibility. *Hair Transplant Forum International*, Special Edition, 1993, p. 4.

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