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ISHRS Achieves ACCME Accreditation!

Paul C. Cotterill, MD, Chair, CME Committee *Toronto, Ontario, Canada*;
Victoria Ceh, MPA, Executive Director *Chicago, Illinois*

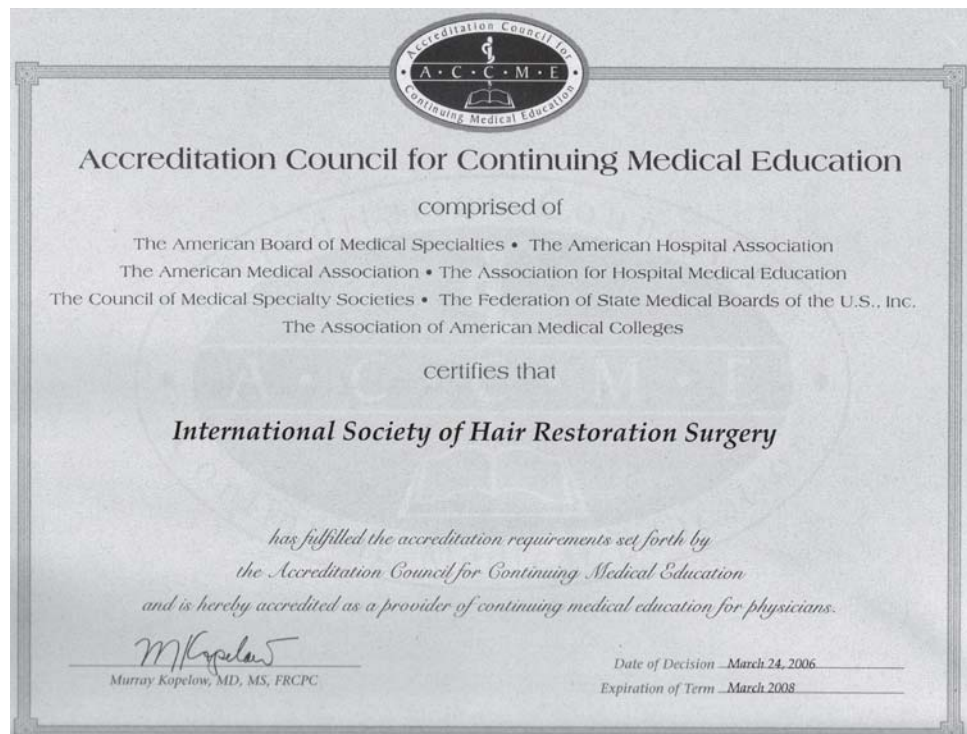
Great news! In March of 2006 the ISHRS, for the first time, became accredited by the Accreditation Council for Continuing Medical Education (ACCME). This is an important milestone for the ISHRS and will assure our members and meeting attendees that all ISHRS educational events are top-notch, high-quality continuing medical education (CME) that will result in improved patient care.

We are now able to designate ISHRS educational activities with *AMA PRA Category 1 Credits™*. All physicians are eligible to be awarded this credit. For U.S. physicians, our meetings will be more valuable because they can directly apply this credit. In the United States, physicians must earn a certain number of CME credits each year to maintain and renew their licenses to practice medicine. *AMA PRA Category 1 Credits* are nationally-recognized in the United States by all state licensing boards, hospitals, and medical specialty boards as official CME credits. The number of CME credits required varies by state; 40 states require some number of CME for license renewal.

What Is PRA?

As a way to simplify the medical re-licensure process, the American Medical Association (AMA) created the Physician Recognition Award (PRA). To earn the PRA, physicians must participate in at least 50 credits per year of educational activities that meet AMA standards. Thirty-four of the 50 U.S. states accept the PRA as proof of completion of their CME requirement (American Medical Association (AMA) website, www.ama-assn.org). The AMA oversees the PRA program and the AMA PRA Credit system.

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Registration is
now open for the
ISHRS
14th Annual Meeting

Hotel del Coronado
San Diego, California
October 18–22, 2006

President's Message

Paul T. Rose, MD, JD Tampa, Florida



Paul T. Rose, MD, JD

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Hair Transplant Forum International is a privately published newsletter of the International Society of Hair Restoration Surgery. Its contents are solely the opinions of the authors and are not formally "peer reviewed" before publication. To facilitate the free exchange of information, a less stringent standard is employed to evaluate the scientific accuracy of the letters and articles published in the *Forum*. The standard of proof required for letters and articles is not to be compared with that of formal medical journals. The newsletter was designed to be and continues to be a printed forum where specialists and beginners in hair restoration techniques can exchange thoughts, experiences, opinions, and pilot studies on all matters relating to hair restoration. The contents of this publication are not to be quoted without the above disclaimer.

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As hair restoration surgeons we often lament that we are viewed with a jaundiced eye by our colleagues and patients. Our field is marred by accusations of unsavory business practices and results that can leave patients with an unnatural appearance.

We know, however, that we can reliably produce superb outcomes; and we know that while there are always going to be those who act in a disreputable fashion, our field as a whole continues to improve. A major reason for our advances is the ISHRS. It is at the vanguard educating physicians, patients, and the media.

Over the past few years, we have undertaken several ambitious tasks. Today, I can tell you that we have delivered on attaining several of these goals.

Just looking at the cover of this issue of the *Forum* you can see that we have taken a remarkable step in the direction of credibility. We have obtained accreditation from the ACCME. This accomplishment allows us to offer our own CME credit for ISHRS programs, as well as CME credits to other organizations seeking certification for their events. This will also enable us to offer CME credits on-line, through the *Forum*, as well as through other possible means.

We are particularly indebted to Dr. Paul Cotterill, who chaired the Committee, and Victoria Ceh, Executive Director of the ISHRS. I also wish to thank the members of the CME Committee for providing their time and input into the process.

The ISHRS has also obtained a seat within the AMA Specialty & Services Society (SSS). This will afford us a voice in organized medicine and could be a springboard for recognition of our field. Dr. Tony Mangubat and Victoria Ceh will represent us at the upcoming meeting in June.

Additional exciting news comes from our efforts to seek American Board of Medical Specialties (ABMS) certification. The initial overtures made by Dr. Bill Parsley have been well received, and an ad hoc committee has been formed to advance this goal.

Apart from our effort to obtain various types of accreditation, we have routinely provided superb educational opportunities for physicians and assistants. This was clearly evident in the recent Annual Live Surgery Workshop held in Orlando. This meeting, under the direction of Dr. Matt Leavitt, has been one of the most popular meetings since its inception. This year was no exception.

The meeting brought together many of the world's foremost hair restoration physicians. The curriculum covered a wide array of topics for beginners and experienced physicians. For my own part, there were quite a few pearls that I took away from the meeting.

I would like to extend my thanks and that of the ISHRS to those individuals who volunteered their time to teach and organize. In particular, thanks go to Drs. Matt Leavitt and David Perez-Meza, and to Workshop Coordinator, Valarie Montalbano, and the staff at MHR for their gracious hospitality and enthusiasm.

I look forward to seeing you all in San Diego this October.

Paul T. Rose, MD, JD



Co-Editors' Messages

Robert S. Haber, MD *Cleveland, Ohio*



Robert S. Haber, MD

Sometimes, we fight growing older. In kindergarten all we do is play, and life is perfectly pleasant when fingerpainting is our most difficult daily task. In grade school, we learn stuff, but we still have lots of time for recess. As we go along, homework assignments begin, the challenges become greater, and we naturally wonder why these changes are necessary. The teenage years include the greatest changes in responsibility. The change from high school to college involves a leap forward in seriousness, attention to detail, and difficulty.

And so there are those who wonder why recent changes within the ISHRS have been necessary. After all, the meetings of a decade ago were great learning experiences, and there were few formal processes involved in becoming a speaker. The program chairman flew by the seat of the pants, and we weren't too demanding about the scientific method.

But now the ISHRS is a teenager, and the reasons for these changes are valid. Within the pages of this issue are two very important articles. The first is our lead article an-

nouncing that the ISHRS has been granted ACCME accreditation. This does not simply mean that we can now grant CME credits to eligible physicians. What it really means is that the ISHRS has been able to demonstrate, via strict, objective criteria, that we are offering educational activities of the very highest caliber. Therefore, even those members who are not eligible for CME credits can now be certain that attending our meetings will be valuable. This is not a small accomplishment. Of the hundreds of surgical societies, boards, and organizations that are similar to ours, only a tiny handful has been able to achieve ACCME accreditation.

We are not the Society we were ten or even five years ago. We are better. And now we must raise the bar even further.

This is huge for us, for by catapulting us beyond most other societies, it will be more apparent to our non-HT colleagues that we

have come of age. I am fortunate to be serving on the CME Committee that has worked hard for the past several years to achieve this goal, and I can say without reservation that the extraordinary focus and levelheaded approach by the Chair, Paul Cotterill, played a major role in our success. If he approaches his upcoming presidency with the same zeal, we will all indeed be fortunate.

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



Jerry E. Cooley, MD

In last month's issue, Dr. William Rassman outlined the many obstacles facing someone who wants to enter our field. He offers a compelling argument that the surgeon who is considering performing hair transplantation because it appears to be "easy money" should rethink that position. However, the article ends on a note of pessimism about the prospects for new surgeons.

I agree that there are considerable barriers to entering and succeeding at hair restoration today. I also believe that a surgeon who is motivated by the right reasons and shows perseverance and tenacity can succeed. As Albert Camus said: "All things considered, a determined soul will always manage."

The environment today is certainly competitive, but is that so bad? It seems to me that the focus of our competition is mostly on patient outcomes, as it should be. Excellent marketing without excellent surgical results is unlikely to bring much success. The converse of this is that excellent results and lousy marketing can bring success as happy patients provide word-of-mouth referrals to their family and friends, and on the Internet. Of course,

excellent results and excellent marketing is the ideal combination.

A beginner who observes a state-of-the-art follicular unit transplantation procedure can easily be overwhelmed: Where does one start? What is most important? In my opinion, excellent *slivering* and *placing* are the two most important procedural skills for the beginning surgeon to master. Assuming one is not able to hire experienced staff, training one assistant to become a proficient *sliverer* is crucial. Other less highly trained assistants can create high-quality grafts if they are given good slivers.

I believe it's a good idea for the beginning surgeon to master the *placing* of grafts before delegating this task to the assistants. If the surgeon masters these skills, other assistants can be trained under his or her supervision, and this activity can gradually be delegated. In my practice, I still do a large portion of the placing because I feel it is so important to the final outcome.

Learning to place grafts gently into 1 to 2 millimeter incisions is the first step. When this skill has been mastered, one can begin the much more difficult task of placing grafts into 0.5 to 1.0 millimeter incisions. Beautifully dissected grafts can be turned into mush in the hands of a rough placer.

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Haber's Message

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The second seminal article is by Drs. Andreas Finner, Berthold Rzany, and Jerry Shapiro, which outlines the many reasons for incorporating evidence based medicine much more aggressively into our studies, presentations, and meetings. If we are ever to truly achieve "Specialty" status, we must not be dependant so much on the anecdotal "research" that remains so prevalent. The fact that the type of surgery

that we do does not readily lend itself to double blind placebo controlled studies is not sufficient justification to avoid the effort. Finner et al. outline several strategies whereby we can achieve a higher degree of scientific validity, and now that we are ACCME accredited, we have no choice but to take this road. Upon graduating from college, we are able to understand why the higher standards are necessary. We are not the Society we were ten or even five years ago. We are better. And now we must raise the bar even further.

Bob Haber, MD

Cooley's Message

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Excellent placement of grafts requires a fine pair of forceps, delicate finger motions, and an artistic eye to know where to place each graft to get the best result.

Of course, other skills are important. But the beginning surgeon and team that can efficiently sliver the strip and place the grafts well have acquired two skills crucial for success.

Jerry Cooley, MD

NEW**DOCTORS – BRING YOUR ASSISTANTS TO THE SAN DIEGO ANNUAL MEETING!**
Surgical Assistants Cutting/Placing Workshop
Wednesday/October 18, 2006—at the Annual Scientific Meeting

Learn to cut and place grafts of various sizes utilizing a variety of instruments and techniques. The Surgical Assistants Cutting/Placing Workshop will be a hands-on environment using human cadaver scalp. Students will be assigned to small groups and will formally rotate among several stations. The workshop is geared toward novice-level assistants and techs, however, experienced assistants will also find the workshop interesting and useful. Faculty and students will share their pearls and personal techniques in slivering, cutting, and placing as well as sharing helpful teaching aides for training staff. Enrollment is limited to purposely maintain a low student to faculty ratio.

Learner objectives:

- ✓ Compare various instruments used for the preparation of the grafts and the placing of the grafts.
- ✓ Identify helpful teaching aides in training staff.
- ✓ Demonstrate preparation of slivers and grafts with human cadaver scalp tissue and planting of follicular unit grafts into cadaver scalp.

Laboratory Fee: The registration fee for this course includes a **Surgical Assistants Kit**. The Kit includes necessary supplies and instruments to participate in the course (e.g., variety of blades and forceps). Students will take home their Kit. In addition, students may bring their own personal favorite instruments for their use during the course, if they wish.

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Please send all submissions and author consent release forms electronically via e-mail. Remember to include all photos and figures referred to in your article as separate attachments (JPEG, Tiff, or Bitmap). Be sure to ATTACH your file(s)—DO NOT embed them in the e-mail itself.

An Author Consent Release Form must accompany ALL submissions.

The form can be obtained in the Members Only section of the ISHRS website, under the section "Forum Newsletter," at <http://www.ishrs.org/members/member-index.php>.

Send article AND release form to:

Robert Haber, MD

E-mail: HaberForum@aol.com

Submission deadline:
 July/August, June 10



Notes from the Editor Emeritus

Dow B. Stough, MD Hot Springs, Arkansas (Forum Editor 1999–2001)



Dow B. Stough, MD

Tension Donor Dissection: The Ultimate Strip Harvesting Method?

There are a number of techniques available for donor harvesting. The majority of surgeons have abandoned the multi-bladed knife due to high hair shaft transection rates. Critics argue “follicular holocaust,” and cite the unpredictability of high transection rates between 8% and 20% when carefully evaluated under microscopes. Some still advocate this method as a fast, efficient producer of donor strips ready for dissection. All concede these strips are much more time efficient, albeit with a heavy price to pay in terms of transection. Many staunch advocates of strict microscopic donor strip dissection remain somewhat cavalier regarding minimizing transection while using a single blade. Why the dichotomy? The majority of current techniques emphasize angling a single blade parallel to the hair shaft to minimize transection. Even with careful attention to hair shaft angling and tumescent anesthesia, transection is always present to some degree. A different technique, originally developed by Dr. Damkerng Pathomvanich of Bangkok, Thailand, offers an alternative to traditional harvesting methods.¹ No degree of experience in blade angling or “following the parallel path of the hair shafts” can match the minimal transection that is possible with this technique. Thus, regardless of your exper-

tise with a single blade, surgeons will find themselves “no match” for a well-executed case of tension donor dissection. In select cases, the rate of transection is less than 1%.

Donor Strip Harvesting

Most surgeons favor taking a single, elliptical donor strip from the occipital scalp that ranges in width from 8mm to 1.5cm. The width must be determined prior to surgery. Each case must be individualized based on donor tissue laxity, donor tissue density, and previous scars. The more laxity, the wider the donor strip that can be harvested. Likewise, the greater the donor area density, the shorter the donor strip length required. Previous scars usually necessitate a decreased width due to tension. We carefully gauge laxity prior to any decision on strip width. We strive for long, narrow strips ranging from 7mm to 1cm in width, and over 17cm in length. This utilizes the donor area in the most efficient manner. Short, fat strips greater than 1cm taken centrally from the occiput will quickly deplete the mid-occipital area, leave the periphery untouched, and create unnecessary central tension. The resultant scars may or may not be cosmetically noticeable. Dr. Mario Marzola has stated: “Make the strip as long and thin as possible, even for small number graft sessions. The one immutable law on best scar outcome is: no tension on closure.”² Dr. Marzola goes on to say that “the patient must be told that the wider strip of 10–20mm will result in an easily identifiable scar, even though it will still be well hidden by the fall of hair. There is no escaping this reality. The invisible scar is only achievable with follicular unit graft procedures somewhere near 2,000 or less.” These sage comments should be understood by both the physician and the patient.

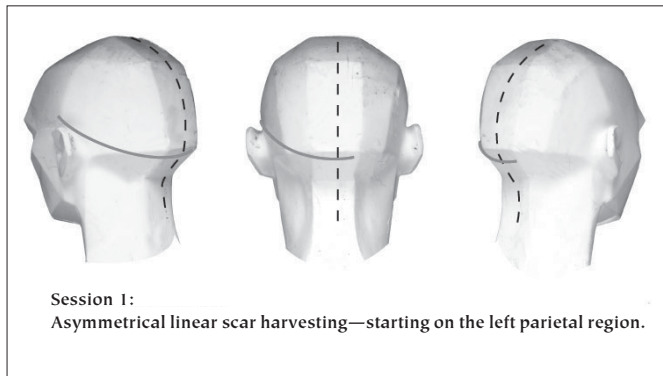


Figure 1.

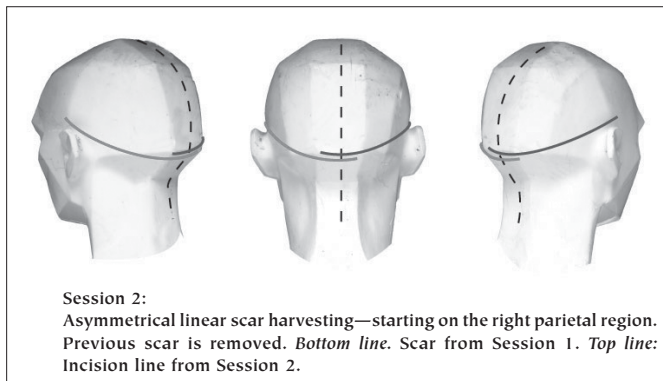


Figure 2.

Previous Scarring Considerations

We always remove the previous scar, positioning it at the bottom of the fresh donor strip. When possible, the strips are offset from the midline toward the periphery. (Figures 1, 2, and 3). The result for the patient is always one single scar.

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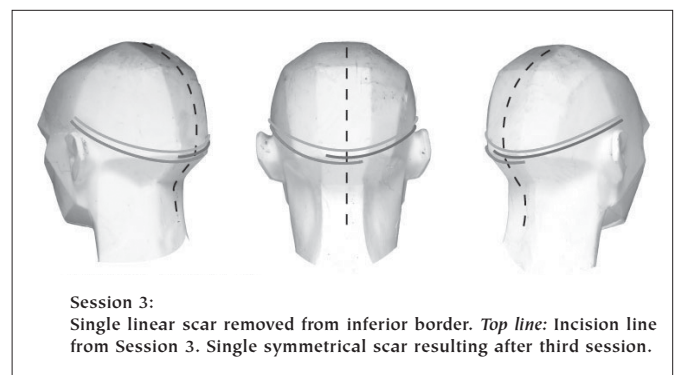


Figure 3.

Editor Emeritus

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Harvesting

Prior to surgery, 15cc of 0.5% Lidocaine with 1:200,000 epinephrine is administered to the donor area. Immediately before excising the area, 20–40cc's of saline solution is injected to create dermal turgor. We utilize 3cc syringes to administer this saline. Syringes larger than 3cc cannot achieve firm tumescence of the occipital area, which assists in minimizing follicular unit transection.

The goal of donor strip removal is to minimize transection of hair follicles, both during the harvesting phase and the dissection phase. Using an elliptical incision with a double blade, one scores the surface of the scalp, being careful not to extend beyond 1mm in depth. The double-bladed knife is used as a template to ensure uniform width of the donor strip, but not as a cutting tool. Likewise, a ruler and a marker can achieve similar results. Traction donor dissection is achieved by utilizing skin hooks in the removal of the donor strip. These small, single hooks must have thick tips and we prefer the Kleinert-Kuts Hook 5" 7mm diameter. These hooks produce tension vectors that travel away from the wound (i.e., perpendicular to the wound incision). It is critical that the initial incision into the donor area be made only to a depth of 1mm. Despite the shallow nature of the 1mm incision, every effort is made to produce this incision parallel to the hair shaft. Following this incision, skin hooks are placed 1cm apart. Four skin hooks are utilized with two assistants aiding the surgeon. Each assistant holds two skin



Figure 4. Tension donor dissection

hooks perpendicular to the wound. The surgeon is then able to gently press and “separate” the hair follicles with very minimal cutting or slicing of tissue (Figure 4). The scalpel is used in a manner to “push” the hair follicles apart. It is one in which meticulous care is taken to avoid any

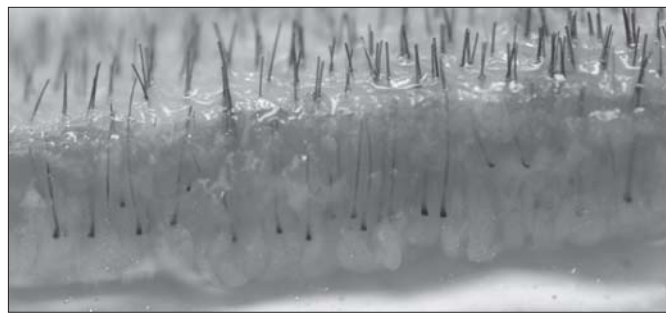


Figure 5. Minimal transection

transection whatsoever (Figure 5). It should be pointed out that in certain individuals the hair follicles in the donor area will completely separate using traction alone and little to no scalpel is required. In these cases, it is possible to achieve close to 0% transection.

Despite benefits of near 0% transection in select cases, tension donor dissection falls short of the ultimate strip harvesting method.

Unfortunately, many patients do not possess the qualities or the inherent

makeup of collagen to allow easy separation. When one encounters a case that can be easily separated with tension alone, it tends to make believers out of the skeptics. Alternatively, Dr. Arturo Sandoval uses a separation technique that employs hemostats to mechanically separate the tissue. He also reports minimal to no transection utilizing this technique. The fundamentals of the hemostat dissection and the skin hook traction dissection method are the same; each employs vector forces to mechanically separate the donor strip from the remainder of the scalp. Dr. Bob Haber has developed an instrument called “The Haber Spreader.” This instrument achieves separation without the potential to bend fragile skin hooks. We look forward to utilizing this innovative instrument.

Problems

Despite benefits of near 0% transection in select cases, tension donor dissection falls short of the ultimate strip harvesting method. The vast majority of cases do not easily separate; the equipment necessary for this technique is still being developed; and one can dispute the significance of no transection along such a small portion of donor tissue. Time will tell the rest of the story. ♦

The author has no financial interest in any of the above-mentioned products.

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