Surgeon of the Month

Antonio Ruston, MD

Vance W. Elliott, MD *Edmonton, Alberta, Canada*

Antonio Ruston, MD
Sao Paulo, Brazil

Antonio Ruston was born in São Paulo, Brazil, and is the older of two sons. He was raised and completed high school in the countryside of São Paulo State. He went on to attend medical school at São Paulo State University in Botucatu city.

As is true with many doctors, Tony's desire to practice medicine came from the motivation to help people, in particular children. Early on he realized that he had an affinity and natural skills for surgery, although he had no idea which surgical specialty he would choose until the last year of medical school, when a friend asked him to help assist him in a breast reconstruction surgery. The surgery took about seven hours and he says that he did not sense the passing of time as he was so involved in the process. From that day, he knew he would become a plastic surgeon.

After he completed his medical degree, Tony moved to São Paulo for his residency (two years of general surgery and three years of plastic surgery at Oswaldo Cruz hospital). Like many doctors beginning a career, he spent almost all of his "free" time working as an ER physician trying to survive financially in a big city, and did so for five or six years after his residency until his practice developed. During this period, Tony also had other experiences in emergency medicine such as working on the main highway in Brazil as an "asphalt angel" rescuing car accident victims, working with NGOs (non-governmental organizations), and traveling to countries such as India, Nicaragua, and countries in Africa, which had suffered natural catastrophes or civil wars, to help people.

During his last year of residency in plastic surgery, Tony began to notice a minor balding in himself. This bothered him as he was still quite young. He then decided to visit "the best hair transplant surgeon" who had been recommended to him by some doctors he knew, and underwent his first surgery. The result was far less pleasing than what he expected and made him think, "If this is the best hair transplant surgeon, could this be the best possible result?"

In his last year of plastic surgery residency, Tony decided to more deeply explore the subject and started performing his first hair transplant cases. He started with small sessions and encountered many obstacles and difficult situations typical of beginners.

After completing his plastic surgery residency in 1995, Tony set out to learn how to perform this surgery, to see the best HT centers in the world, and to discover what this field that so fascinated him was all about. He spent 3 months traveling to many countries visiting clinics, among them that of Dr. Pierre Bedard in Montreal, who was the first to tell him about a new society called the International Society of Hair Restoration Surgery.

Tony became a member of the ISHRS and since 1999 he has been attending all of the international meetings and many of the live workshops around the world as a participant and speaker. He always takes the opportunity to visit colleagues such as Drs. David Perez-Mesa, Matt Leavitt, Ken Washenik, Ed Suddleson, Ron Shapiro, Walter Unger, and Bill Rassman (whom he considers to be one of the most inventive in our field). He wishes to express his gratitude to those as well as others for their wonderful hospitality. He says that he always learns something new, such as a new instrument or a new idea, that has added value to his current practice.

Tony's clinic is in the city of São Paulo, Brazil, and he also has an office in Rio de Janeiro where he goes on Saturdays. He performs just one hair transplant per day, and he stays the whole time during the procedure, which takes about six hours. They are always megasessions with an average of 2,200–2,500 grafts (sometimes reaching 3,000).

Tony's surgical team is composed of another plastic surgeon, Dr. Tulio di Piero (who has become his right hand over the past 5 years), and 6 surgical assistants. He uses only microscopic follicular unit transplantation and, like all perfectionists, his true desire is to offer increasingly more natural results that cannot be detected by anyone under any circumstances. He has been working for nearly 4 years with the concept of ultra-fine single hairs to create a natural transition and a feathery aspect normally found in natural hairlines.

Tony ardently fights the stigma that this surgery bears and says that as long as bad professionals and obsolete techniques are still to be found in this field, the stigma will remain, because it only takes one bad result to discourage hundreds of potential patients.

Regarding his own hair, Tony says that he is satisfied with two corrections that he had done, one with his own team, and another with his friend, Ron Shapiro, but he still wishes to apply the ultra-fine technique to refine and perfect the appearance of his own frontal hairline.

Tony is single and says that he has never found himself at the right moment to build a family, in part due to lack of time, but says that this is one of his new personal goals. Tony has always done (and continues to do) philanthropic work, performing free surgeries when possible, and related activities.

Some of Tony's many hobbies are traveling, discovering new cultures and languages, and diving. However, his greatest passion without a doubt, besides surgery, is singing and producing his own shows. He has done this since his youth, going from playing guitar and singing in bars during his college years to the present, where every year he does one big show in São Paulo, each with a different theme (movie sound tracks, pop rock, and of course, Elvis). He says that it is his way of blowing off steam and of giving him life force. He says that music is the soul's happiness, improves the state of one's spirit, and facilitates personal relationships. Perhaps this is why in the ISHRS he has made so many and such good friends in what he considers to be a big family with "relatives" all over the world.✧

Pro Bono Program

OPERATION RESTORE

Restoring self-image, self-esteem and hair

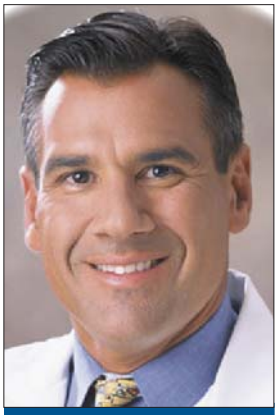
Notice to OPERATION RESTORE Volunteer Physicians—Time to Update Your Files!

It is time for the annual review and update of your pro bono application file with the procedures you are offering to perform as an OPERATION RESTORE Volunteer Physician. You will be prompted by an e-mail from the ISHRS to review and update the information we have on record. It is important for the matching process to keep this information up-to-date. Please be sure to respond to this e-mail. Thank you!

Pioneer of the Month

Robert T. Leonard, DO

William M. Parsley, MD *Louisville, Kentucky*



Robert T. Leonard, DO
Cranston, Rhode Island

For years he has been known for his work promoting ethics, but there is much more to know about one of our early presidents and visionaries in the ISHRS. An ancestral mixture of Irish/Greek, he was born Robert Thomas Leonard, Jr. on April 17, 1959, in Cambridge, Massachusetts, and was raised in nearby Arlington along with his two sisters.

These roots led him to become a diehard fan of the Boston Red Sox, who finally won the World Series in 2004, ending the 86-year-old "curse" placed on them for selling legendary Babe Ruth to the New York Yankees. But Bob had plenty of success in life before this event.

Bob attended college at the University of New Hampshire as a pre-med major and did his medical training at the University of New England College of Osteopathic Medicine (UNECOM) in Maine, finishing in 1986. It was at UNECOM that he made his wisest decision, marrying classmate Kathy Gagne. They both interned at Metropolitan General Hospital in St. Petersburg, Florida, and Bob had plans to specialize in Obstetrics/Gynecology. During this internship year, he met C.P. Chambers, DO, on a fund-raising visit at the request of UNECOM. They hit it off immediately, and Bob spent as much of his free time as possible visiting Dr. Chambers' office. However, he still wanted to pursue Ob/Gyn and started residency training at Parkview Hospital in Toledo, Ohio, the next year. He was so busy that he soon realized that this field wouldn't allow time for Kathy, who was pregnant with their first child at the time, and his future family. He called Dr. Chambers and took him up on his offer to train Bob and have Bob work for him. The experience was extremely meaningful to Bob, as he felt Dr. Chambers was ahead of his time. He learned the "Dovetail Closure" where rows of grafts were removed, then sutured with a tongue-in-groove closure; and also learned the "Hat's-Off Technique," in which the recipient plugs where secured with a retention suture, eliminating the need for a bandage. To this day, Dr. Leonard has never used a bandage on a patient.

The Leonard family (L to R): Michael, Kathy, Victoria, Alexandra, and Bob.

Bob had plans to return to New England, where it was considered very important to be board certified. To that effect, he entered and completed a Family Practice Residency, still at Parkview Hospital, in 1988. Next, Bob returned to New England and set up practice in Providence, Rhode Island, under the name "Chambers Hair Institute of Rhode Island," but he also worked in Chambers' clinics elsewhere (Detroit; Clearwater; Orlando; and Warren, Ohio). A few years later, Bob went on his own and changed his Providence practice to "Leonard Hair Transplant Associates." He then opened additional offices in Massachusetts. Soon he became known as the only hair transplant surgeon in New England who sutured the donor area, sutured the recipient sites, and used no bandages—allowing patients to return to work right away.

At this time, he heard about a new hair restoration society being formed and was having its first meeting in Dallas. This was 1993 and the organization was the ISHRS. Bob called Dow Stough, MD, and volunteered to help in any way. They made him Exhibits Chairman and at the meeting he was selected to be the first Secretary of the ISHRS. But everything wasn't perfect. Within the field of hair restoration, he saw unethical business practices and denigration of colleagues occurring to an alarming degree. That is when he embarked on a career mission to raise the ethical standards of our profession. He was one of the founding members of the Bylaws and Ethics Committee, and along with Paul Straub, MD, wrote our first Society documents in these important areas. In the mid-1990s, he participated in the formation of the American Board of Hair Restoration Surgery, a task that occupied a great deal of his time. Among many other positions he has held, he was president of the ISHRS in 1995–96. He has become a speaker and educator, presenting at national and international meetings, including the Italian Society of Hair Restoration and European Society of Hair Restoration Surgery. Presently Bob is the editor of the popular *Forum* column, Pearls of Wisdom.

Bob's family life is very important to him. He and Kathy have three children: Alexandra, born in 1988, Michael, 1989, and Victoria, 1993—all probably Red Sox fans. ✧

Cyberspace Chat

Jennifer H. Martinick, MBBS *Perth Australia*
info@image21.com.au

PCPT TRIAL CONCERNS

How pathology review refuted initial concerns about high-grade prostate cancers using finasteride.

Edwin S. Epstein, MD *Richmond, Virginia*

The initial concern was that finasteride was inducing a higher grade cancer. Under the induction theory, one would expect a greater incidence of high-grade cancer over the course of the study and this did not occur. The greater number of patients was diagnosed in the first year. This was explained by the fact that finasteride reduces the BPH component of prostate size and thereby increases the number of positive biopsies. Finally, the question was raised whether finasteride could induce changes that resembled higher grade changes. When the high-grade cancers were separated into finasteride and control groups, the three pathologists who independently reviewed the slides could only agree on about 50%; that is, that the higher Gleason grades were initially over read.

CYST FORMATION POST-TRANSPLANT

William M. Parsley, MD *Louisville, Kentucky*

In my view, these are the possible causes of cysts:

1. Hair spicules left in the skin
2. Transected existing recipient hair follicles causing ingrown hairs
3. Transected existing recipient hair follicles growing into the tracts of transplanted hair
4. Dead grafts
5. Buried grafts
6. Transected grafts leaving the upper follicle that can't form a new hair
7. Transected grafts leaving the lower follicle that can't form a new hair
8. Infection (this would only be very soon after transplanting)
9. Buried silica or fabric (if grafts are on gauze)

I believe #5 and #7 are the main culprits at three months because that is when the follicle enters anagen and becomes active. They have lost the tract to the skin surface, and so create a cyst with a hair.

Michael L. Beehner, MD *Saratoga Springs, New York*

"Cysts" are two different problems in my view. There are epidermoid inclusion cysts that, when incised and drained, yield a curled up growing hair, or the bottom partner of a piggy-back combination of one graft placed on top of the other.

Then there is the much more common occurrence of pimply bumps in various spots of the recipient area, probably related to an abnormal reaction to sebum, and possibly also egged on by small spicules of retained hair fragments. I treat them by putting the patients on daily tetracycline or erythromycin for a couple of months and have them also lather their scalp with Phisohex (chlorhexidene) soap 2–3 times a week.

Francisco Jimenez-Acosta, MD *Las Palmas, Spain*

The main cause of cysts is buried grafts, which are full hair follicles that continue to grow hair shafts within the skin.

Hair spicules do not grow. Macrophages remove them, avoiding cyst formation.

SLEEP ANGLE, EDEMA, AND BUFFERING

John Cole, MD *Atlanta, Georgia*

My impression is that sleeping upright to reduce facial swelling has been a longtime myth following hair transplant surgery. Fluid goes to the dependent area as long as resistance is equal. Sleeping upright will result in fluid flowing down towards the face. Lying flat will help the fluid flow backwards.

Ken Washenik, MD, PhD *Beverly Hills, California*

After decades of having patients sleep at an elevated angle, we switched to sleeping flat. Patients still swell from time to time but the fluid is much less evident as it drains posteriorly.

I have heard that some surgeons do not buffer lidocaine with sodium bicarbonate because it causes an increase in edema. I have not noticed an increase in forehead swelling even for hairline anesthesia using a buffer.

William Rassman, MD *Los Angeles, California*

Buffering lidocaine will decrease the effect time of the drug. Acid decreases circulation while a base increases it, and when added to the lidocaine, the same effect will apply.

Carlos J. Puig DO *Houston, Texas*

To streamline the post-operative inconvenience and hassle for the patient, I use:

1. Marcaine-lidocaine mixture as a ring block using less than 30cc in total. I use Klein solution with Kenalog 40mg added to each liter of tumescence solution. Seldom is the total volume used more than 175cc. The patient starts a Medrol dose pack the day before surgery and has an additional 24mg about 20 minutes before starting the case. They finish the Medrol dose pack the next day.
2. Graftcyte post-operative kit is used for the first 5–7 days.
3. All patients are told to sleep at no higher than a 45° angle for the first two nights, mainly to keep them from rolling on their side or stomach.
4. I recommend using frozen peas to the forehead below the grafts, not on the grafts, for the first 12–24 hours.

With this routine our post-operative edema is minimal and controlled, the crusts come off between day 4 and 14, and the patients can usually return to work within 2–3 days.

I believe this routine will be improved by using low-level laser therapy immediately after surgery, the next day, and three times a week for three weeks. Only 10 patients have been treated this way but I'm very impressed as their crusts are gone by day 5–6, and in 30 days there is still hair in 75% of the grafts.

Russell Knudsen, MBBS *Sydney, Australia*

My routine is:

1. Betamethasone valerate 1cc IM pre-operatively.
2. Kenacort 10, 1cc into 50 ml of normal saline for recipient and donor areas.
3. No post-operative steroids, but the application of an ice pack to the frontal recipient area for 10 minutes each hour for the next 12 hours.
4. With any visible frontal forehead swelling, a headband is applied above the eyebrows.
5. Post-operative analgesia with ibuprofen + /- codeine.

Richard C. Shiell, MBBS *Melbourne, Australia*

I think that swelling is related to the degree of intra-operative bleeding, and if I can get a really dry field, there will be very little swelling.

Bobby L. Limmer, MD *San Antonio, Texas*

My experience with buffered lidocaine in the recipient area was a very high rate of forehead and periocular edema. We still use it in the donor area but never in the recipient area.

William Reed II, MD *La Jolla, California*

It seems the swelling presenting at day 3 is from the inflammation of the healing process. Swelling is "dose related." Low numbers of sites cause less swelling/inflammation than higher numbers. The swelling is responsive to anti-inflammatories/steroids. Occasionally a different type of swelling occurs on day 1 and seems associated with excessive bleeding during the procedure. Immediate fluid/blood loss is the cause. It also shows infraorbital ecchyomotic discoloration a week later. Redness does occur in fair-complected people.

PERSISTENT HICCUPS

Richard Shiell, MBBS *Melbourne, Australia*

Persistent hiccups was not uncommon in the days when I used 10mg of intravenous Valium pre-operatively. It disappeared immediately when I switched to 5mg of intravenous Versed in 1986 and has NEVER returned in my many thousands of HT cases since that time.

In 1995 Jim Arnold wrote an interesting article in the *Forum* (Vol. 5, No. 5, page 21) suggesting an association between hiccups and the irritation of an aberrant sensory branch of the phrenic nerve. I was not a convert to this suggestion and believed that at least what I was seeing was chiefly a pharmacological reaction to the pre-operative medication. I am sure I cut and irritated a lot of nerves in my 40 years as a hair transplanter, but why did the hiccups suddenly stop in 1986 if the explanation was not pharmacological? It is pretty much a result of the speed of IV infusion.

Michael L. Beehner, MD *Saratoga Springs, New York*

I did a father-son combination the same day, both receiving IV Valium, and both did fine during the case, but that evening *both* had moderately persistent hiccups that lasted till the next day. I put them on PO Thorazine and they stopped within a few hours.

Ativan (lorazepam), is one of the benzodiazepine family along with midazolam, diazepam, and others, but has a half-life of 12–24 hours compared with >24 hours for Valium and less than 6 hours for Versed.

TRAINING TECHNICIANS

James E.Vogel, MD *Baltimore, Maryland*

Something I have not figured out in 16 years of practice is the best way to get a great hair tech. In the past, I have advertised for trained techs, hired and tried to train med techs, nurses, scrub techs, cosmetologists, and secretaries and still do not have the best approach, and still find myself in need of 1 or 2 solid additional people. I would really like to know what have been your most successful methods to seek out and secure the best hair techs?

Vance W. Elliott, MD *Sherwood Park, Alberta, Canada*

I agree that this is difficult. One thing that constantly worries me about our field is how dependant we are on our staff.

Placing rapidly, gently, and accurately is the most difficult skill to develop. I have been giving serious consideration to going to all stick-and-place (done by me), to eliminate my dependence on staff placers.

William Rassman, MD *Los Angeles, California*

I have the placing problem *solved* with instruments that I have developed. I do not use them myself because they would put much of my wonderful staff out of work and instruments do not substitute for Tender Loving Care that my huge staff provides. The new instrument I have will allow even the smallest grafts to be used, and another instrument we have now tested will allow percutaneous placement without pre-made sites for a graft of any size. I have already worked out the problem of critical staff for placing as all of my staff is cross trained.

Jerry Wong, MD *Vancouver, BC, Canada*

I had the most success with people who are good with their hands, i.e., artists or art students. Maybe see if there's a young Asian waitress with nimble fingers looking for work.

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

I have staff cross-trained on slivering and cutting. I've found that doing a large portion of the placing myself has ensured that I have control over the process. Placing is always the bottleneck. It's better if my new techs have no prior experience so they learn it the way I want it done.

Ron Shapiro, MD *Bloomington, Minnesota*

The best way to not be as dependent on placers is to be able to place yourself if needed. Being a good placer helps when your staff is sick, allows you to train new staff faster, and helps you with your decisions about incision size/depth and density to help not choose a combination of these that increases the difficulty of placing. BUT I would always be nervous and held hostage if I could not place well if needed.✧

ISHRS Regional Workshop

Asian Hair Surgery Workshop

Hosted by Kenichiro Imagawa, MD

When:
March 30–April 1, 2007

Where:
Yokohama, Japan

Cost:
$1,500 USD for ISHRS members;
$1,800 USD for non-members
Limited to 30 physicians

For more information:
Contact Dr. Imagawa's office
E-mail: dr@yokobikai.or.jp
Telephone: 81-45-311-8811
Fax: 81-45-312-8866

Overview:
This three-day workshop will include lectures by the tops in Asian hair surgery with live surgery demonstrations.

Presenters:
This workshop will be hosted by Kenichiro Imagawa, MD with the following faculty:

- Damkerng Pathomvanich, MD
- Jerry Wong, MD
- Sungjoo Tommy Hwang, MD
- Paul C. Cotterill, MD
- Kenichiro Imagawa, MD

This regional workshop will contribute to the subject of **Hair Transplantation in the Asians**, and take a close look at the following: the differences among Asian and Caucasian hair, hairline design, donor harvesting and closure, grafts cutting and insertion.

The International Society of Hair Restoration Surgery is accredited by the ACCME to provide continuing medical education for physicians. The International Society of Hair Restoration Surgery designates this educational activity for a maximum of 20.5 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This workshop is filling quickly. Register Online Today!

http://www.ishrs.org/RegionalWorkshop.htm

Dilemmas in Hair Restoration

Robert S. Haber, MD *Cleveland, Ohio*

William M. Parsley, MD, of Louisville, Kentucky, poses this dilemma:

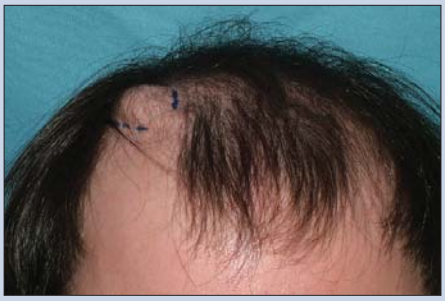
I had a 26-year-old male with a shunt come in this afternoon. In his first year of life, he developed meningitis and the damage required that he have a shunt that hooked to the occipital region. About 15 months ago the shunt quit working and he was semi-comatose for 2 weeks. He had the shunt flushed, but he started blacking out 2 days later. He then had a new shunt placed, which entered into the right frontal lobe area.

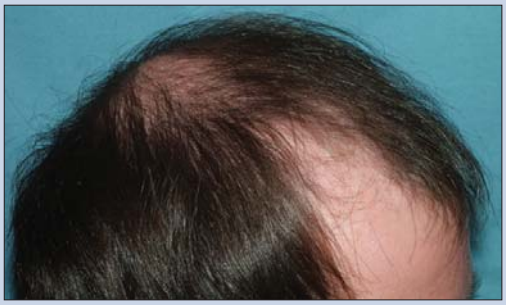
The problem is that the shunt is pretty thick and stands up over a centimeter above the scalp. To make matters worse, he is balding and the shunt stands out even more. His neurosurgeon told him that to make this less obvious is a cosmetic procedure and not covered by insurance (the recent operation cost $80,000). So he would like to have this covered with hair.

He is not on medication, so I put him on finasteride and minoxidil. He mentioned that if he can't fix the shunt and loses more hair, he would prefer to wear a hair piece than to have the shunt show. He also stated he could handle going bald if he didn't have the shunt. His donor hair is slightly fine and has average to less than average density.

His first port was in the mid-occipital region; he was left with a vertical 20 x 7mm scar when the shunt was changed last year. This might give me a problem if I took the donor strip across this scar. He is the baldest guy in the family. His father apparently has a large vertex pattern loss with a retained frontal hairline (a la Al Gore). His shunt extends anterior to any possible created mid-scalp band, and would be well into the frontal zone. I would probably build the parietal humps and create a frontal zone with a temporo-parietal connection. I don't know if the shunt is above or below the galea, but will find out.

I would not operate on this patient (age 26 with this much hair loss) if he had never had a shunt, but the circumstances make me consider it. I'll wait for the response to medication first. The question is: Who would do a transplant on this patient? Has anyone had a similar case? I also worry that there could be some pressure loss over the shunt if I grafted the area.





Jerry Wong, MD *Vancouver, BC, Canada*

The question is how close is the shunt to the surface of the skin? If you have 5mm or more of skin tissue, it would be quite easy to keep the incisions shallow and thus avoid hitting the shunt. Is it possible to do an X-ray or ultrasound to measure the skin thickness? Seeing residual hair over the shunt suggests skin thickness may be OK, but I would want some concrete method (preferably noninvasive) to measure the actual thickness.

Carlos J. Puig, DO *Houston, Texas*

I have operated on three patients who have had VP shunts over the years. Never have I seen one this big. Why is it so large? Also, I have never seen one that comes into the frontal scalp. His stricture in the ventricular system must be rather high. Usually these are small tubes behind the ear, piercing the skull in the parietal area, and the shunt can be worked avoided. I have never had a problem doing these patients, but I do stay at least 2–3cm away from the shunt.

How much donor is lost due to the placement of the shunt considering such an easement? What is the family history of hair loss? Does that compromise the donor even more? Is the frontal placement of the shunt in a location such that you can graft anterior to it and get the growing hair to style over it? Is the shunt in the frontal area in the subgaleal plane? If so, we should seek our colleagues' opinions about the risk of setting grafts into the skin above the shunt.

Shelly Kabaker, MD *Oakland, California*

Last year I had a 45-year-old patient with an almost identical situation who was referred by his neurosurgeon for consideration of transplants to hide the increasingly noticeable port as hair loss progressed. The port was in the exact same place as your patient. He did have less hair loss than your younger patient. The present shunt was in place for 12 years and the prior one was in for 18 years. The dome of the shunt was definitely below the galea per discussion with the neurosurgeon, and it was barely perceptible to the camera. In real life, one could see the outline and in the next few years it would become fully exposed and become a point of curiosity.

I have done 2 sessions of follicular unit grafts (total of 2,400 grafts), being very careful around and over the port and connecting tubing that I marked out pre-operatively. Before making recipient sites in these areas, I tumesced the skin to temporarily thicken it, and was careful to make the slits no deeper than the galea. I made fewer slits over these

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Dilemmas in Hair Restoration

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areas, relying on more densely packed grafts anteriorly to provide the disguise of the shunt.

He had no problems and a very nice result. Had he not had the shunt and the increasingly visible deformity, he would not have considered hair transplants.

I like the idea of conservative grafting in front of the dome port and perhaps avoiding any grafts over it until later sessions and clearance by the neurosurgeon. Perhaps there might be need to revise the shunt again.

Bill Rassman, MD *Los Angeles, California*

I have done a number of patients with large burr holes or metal plates in the skull. For the burr holes, the skin can be slid away from the hole to fill in hair above it. The metal plates were not a problem.

I just did a patient with a shunt (non-communicating hydrocephalus). I felt something of concern, which I thought might be a shunt tube near the scar in the middle of the donor area, so I got a CAT scan after placing 30 gauge needles in the scalp around the area I was feeling. We went for the CAT scan with the patient to be sure that we identified the shunt. The shunt was easily seen to be well outside the donor area and far from what I had palpated. The craniotomy scars in the frontal area where there were depressions were included in the CT scan. There was good bone present, even in the depressed area.

Ken Washenik, MD, PhD *Beverly Hills, California*

I would not place grafts over this shunt. There is no way that grafting is worth the risk, especially considering how fine his hair is. I doubt that transplantation would meet his needs to hide the shunt.

Meds are a definitely a good idea. At his age and duration of hair loss, he could see a significant amount of growth in six months—if he responds well. Still, it is unlikely that this response to meds is durable.

Having said that, I believe his best options are a hairpiece or transferring his shunt to a less obvious location when his neurosurgeon feels that his neurostatus has stabilized. Somehow, his neurosurgeon needs to understand how the present location is not tenable for this young man. The result he has left this young man with is unacceptable – if any other locations are viable options. If his neurosurgeon feels that "this is cosmetic and not worth my time", he should see another neurosurgeon.

Vance Elliott, MD *Edmonton, Alberta, Canada*

I have a few concerns about grafting him. He has a static cosmetic deformity AND a progressive one (AGA). He would not be having HT except for the shunt. That would be a smaller problem were it not for the fact that he has AGA. You may end up having to do more HT in future, unrelated to the shunt appearance, to maintain a natural pattern in someone who never wanted HT in the first place. The problem is not baldness, it is the ugly shunt. I completely understand him wanting to hide it, by the way.

If you operated on him, find out what the shunt is made of (ideally, get a look at one to see what kind of material you are dealing with), and how resistant to needle puncture it would be. The neurosurgeon should tell you whether or not he needs antibiotic prophylaxis.

You could consider using grafts taken from the recipient areas with FUE so that if he went progressively bald, he would lose the grafts too and not be obliged to continue with more transplantation.✧

Follow-up from Bill Parsley

The following information was gained after discussing this case with a neurosurgeon:

First of all, the shunt is sub-galeal. They do make smaller shunts but they are only slightly smaller and are pediatric tubing. To change a shunt is like taking out an artificial hip to put in a new one—a major undertaking. The hole for the shunt is in the skull just anterior to the coronal suture and is the favored place in adults. The occipital area is fine for kids and pediatric tubing is used, but the skull is thicker and more difficult in adults, so the occipital area is not favored.

He didn't think grafting over the shunt should be a problem if one was careful. They will use a 23g needle to draw CSF from the shunt and it nearly always seals over without problems. Also the shunt is tough and you have to give an extra push to get it through. It is unlikely that you would penetrate the tubing if you use reasonable care. One warning: He said to try to avoid making your recipient sites through the galea. In the rare event of any infection, the shunt may have to be re-done. He felt with tumescence and care, it should be fine.

No antibiotics are required for dental work and wouldn't be required for HT. He also didn't think that cutting out the scar of the previous shunt (occipital) should be a problem, but said to feel the area for fluctuance (would be very rare). However, he did say to be very careful about the drainage tubing in the lateral scalp and neck, and suggested it might be best to interrupt the excision over the area of the drainage tubing.

Are You New to the Field or Looking for a Refresher?

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Enduring Material, CD-ROM Format

Sponsored by the International Society of Hair Restoration Surgery

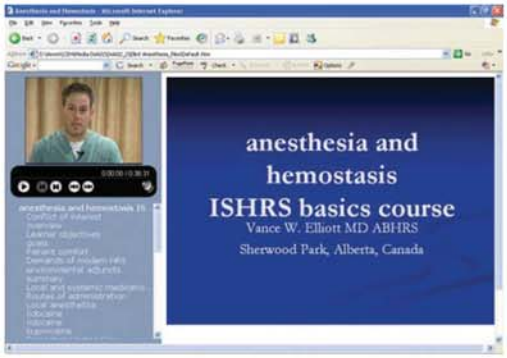
To order your copy, go to: http://www.ishrs.org/2006-HRS-Basics.html

The 2006 Basics in Hair Restoration Surgery Lecture Series is an enduring material created by the International Society of Hair Restoration Surgery (ISHRS). The Series can be taken alone or paired with the Basics Hands-On Course at the ISHRS Annual Scientific Meeting. The Series provides the didactic information and the Hands-On Course teaches the core skills. When paired with the Hands-On Course, students are expected to complete the Series prior to the Hands-On Course. Together the overall emphasis is to provide basic and core skills essential for the practice of safe, esthetically sound hair restoration surgery. It is intended for use by those new to the field as well as those who are interested in a refresher. This enduring material was developed as a result of the need for the consistent and comprehensive presentation of the core basic topics. A faculty of well-known and distinguished experts in the field developed the materials and content based on the pre-determined learning objectives and with the guidance of the CME Committee.

Continuing Medical Education (CME) Credit:

Sponsored by the International Society of Hair Restoration Surgery. The International Society of Hair Restoration Surgery is accredited by the ACCME to provide continuing medial education for physicians. The International Society of Hair Restoration Surgery designates this educational activity for a maximum of 9.0 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

To receive CME credit participants must participate in the activity, complete the post-test, and achieve a passing grade (70% or higher). Instructions are included on the CD-ROM.



Lectures on the CD-ROM:

Contents and faculty include:

1. History of HRS & ISHRS Course Overview, *Carlos J. Puig, DO*
2. Anatomy & Physiology of Hair Growth, *William M. Parsley, MD*
3. Physiology & Medical Treatment of Hair Loss, *Kenneth J. Washenik, MD, PhD*
4. Identification of Non-Androgenetic Pathological Hair Loss, *Bernard P. Nusbaum, MD*
5. HRS Patient Consult: Ethics, Expectations, and Pt Selection, *Matt L. Leavitt, DO*
6. Hairline & Crown Whorl Design, *Michael L. Beehner, MD*
7. HRS Anesthesia & Hemostasis, *Vance W. Elliott, MD*
8. Donor Harvesting & Closure, *Marcelo Gandelman, MD*
9. Graft Preparation and Storage, *Jerry E. Cooley, MD*
10. Recipient Site Preparation & Graft Placement, *Robert P. Niedbalski, DO*
11. Flaps, Reductions, and Lifts, *E. Antonio Mangubat, MD*
12. Office Emergency Preparedness, *Edwin S. Suddleson, MD*
13. Office Design and Ergonomic Work Stations, *Carlos J. Puig, DO*
14. Basic Principles of Staff Training, *Carlos J. Puig, DO*

Format:

The CD-ROM is computer format, and the following is a list of user/system requirements in order to view the CD-ROM:

- Windows Media Player. This can be downloaded for free at: http://www.microsoft.com/windows/windowsmedia/player/9series/default.aspx
- Microsoft Windows® 98 Second Edition, Windows 2000, Windows Millennium Edition, Windows XP Home Edition, or Windows XP Professional
- A 233 megahertz (MHz) processor, such as an Intel Pentium II or Advanced Micro Devices (AMD) processor
- 64 megabytes (MB)
- CD or DVD drive (DVD playback requires compatible DVD decoder software)
- 16-bit sound card
- Super VGA (800 x 600) or higher resolution
- Speakers or headphones
- Microsoft Internet Explorer 5.01 or Netscape Navigator 4.7

International Society of Hair Restoration Surgery
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Order yours today! www.ishrs.org

Surgical Assistants Editor's Message

Heather Hess, MA *Atlanta, Georgia*


Heather Hess, MA

Hi Assistants,

I hope you all received the e-mail that I recently sent out. It had some fantastic ideas for articles for the *Forum*. These were ideas recommended by the recent survey done for the meeting in San Diego. This is what your fellow assistants said that they would like to hear about. If you didn't receive the e-mail, please let me know and I will send it to you. Make sure we have updated e-mail information on you as well.

This month we have a great article from Patrick Tafoya. I've also been saving your pearls, so look for them to be printed in future issues. We'll try to include them monthly, but sometimes we're short on space.

Here are the topics you'd like to have covered. If you know of any surgical assistant or physician who can write an article, please give them a nudge.

- Camouflage techniques for hair loss, especially after surgery; hairstyling after transplants
- Hair transplantation in scarring alopecia
- Post-op care discussed in detail (specific comments included: post-op care and complications, such as folliculitis, facial edema, telogen effluvium)
- An assistant comment: What does the doctor think is a usable graft and which does he/she feel should not be planted

Keep e-mailing me with your articles and pearls.

Heather Hess
hhess@metroderm.org

Message from the 2007 Surgical Assistants Program Chair


Ailene Russell, NCMA
Charlotte, North Carolina

Dear Surgical Assistant Members,

It is hard to believe it is already 2007! I hope everyone is as excited as I am about going to Las Vegas this year for the 15th Annual Scientific Meeting. I have been busy putting this year's program in place.

The Surgical Assistants Program will run all day on Wednesday, September 26. I have some new speakers who have graciously agreed to participate in the program this year. A broad range of interesting and practical topics will be covered. We are also going to have an expert panel for a question and answer session right after the luncheon. The same evening we hope to have the Surgical Assistants Cutting and Placing Workshop. The live tissue made the last program a huge success, and we would like to repeat this if possible.

There will be a very full schedule with lots of reinforcement of core concepts along with new ideas to explore. I welcome suggestions for this program and ask you to poll your office and doctors to find out what they would like to see addressed in our program. Please feel free to e-mail me at ailenerussell@yahoo.com at any time.

Please share in the excitement of the Surgical Assistants Program. I will need lots of volunteers for different jobs during this event. If you plan to attend and would like to have an active role, please let me know.

Regards,

Ailene Russell, NCMA, Surgical Assistants Chair

Popping: Why It Occurs and How to Prevent It

Patrick A. Tafoya, *Orlando, Florida*

Every curse has been thought of while trying to deal with the phenomenon called "popping." It's probably the most frustrating aspect of implantation. By definition, popping occurs after a graft is implanted into a recipient opening and the graft "pops" back out. It can pop out slowly or rapidly, but either way it can turn a relatively good-natured tech into a raving lunatic.

Many theories have attempted to explain this occurrence (Figure 1). The most common belief is continued bleeding or slow coagulation around the recipient opening. The blood pressure literally pushes the graft back out. Coagulation normally acts like an adhesive to help the graft stay in place. The best solution to this problem is to minimize the bleeding with diluted epinephrine. Always inject epinephrine at the first signs of excessive bleeding, as keeping ahead of bleeding will minimize the frustration.

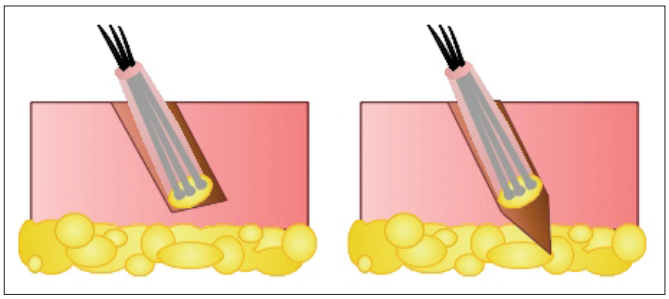


Figure 1. Popping can occur when the opening is too shallow or the base of the opening is too thin.

Other theories include "slippery" grafts, tight or a non-elastic scalp, and "mushy" or fatty scalps. Tissue that is described as "slippery" usually has an oily substance that can be seen floating in the normal saline the grafts are stored in. This substance makes the grafts more difficult to control with forceps. Each graft has to have slight pressure held over it longer than usual until it "settles in" and stays in place.

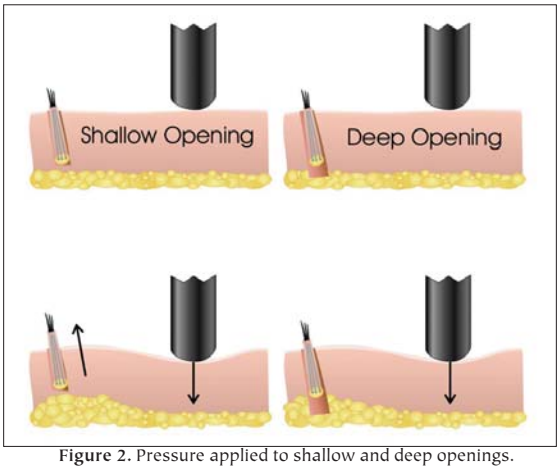


Figure 2. Pressure applied to shallow and deep openings.

A tight or non-elastic scalp will not expand as much and cannot hold as many grafts as a more "spongy" scalp. You will know its limit when you implant 1 graft and 5–10 adjacent grafts "pop" out. Whenever a tight scalp's recipient opening is expanded to hold a graft, the expansion presses into the adjacent grafts and the excessive pressure results in extreme "popping". There may be times when filling every recipient opening (if too closely spaced) is not possible.

The last theory is the "fatty" scalp. Imagine a scalp is similar to a waterbed. When one person is sitting on one side of a waterbed and another person jumps on the other side, the first person will bounce due to the wave of water that is pushed under the first person resulting in a "popping" effect. If the scalp has more than an average amount of adipose tissue, this "popping" effect can also occur (Figure 2). The best way to prevent this effect is to make the openings deeper than the length of the grafts. The extra depth will keep the fatty tissue from pushing into the grafts.

These are a few theories on the "popping" effect and their possible remedies. Understanding the causes can help alleviate the frustrations.✧

Classified Ads

Experienced Hair Technician Needed

Per diem. All inquires strictly confidential.

New practice in Palm Springs, Ca.

Please call 760-416-6971 or fax resume 760-318-8103.

Hair Transplant Office Manager and Technicians Needed in Las Vegas, Nevada

Technician must be experienced with microscope and placement. Inquires confidential.

702-376-1445 (cell) or 702-258-6229. Fax resume: 702-258-8925.

Experienced Hair Technicians Needed

Per diem work. All inquires strictly confidential.

New practice in coastal New Jersey (Monmouth/Ocean County).

Please call 732-449-3005 or fax resume 732-449-5110.

Experienced Hair Technicians Needed

Inquiries confidential; *per diem* work.

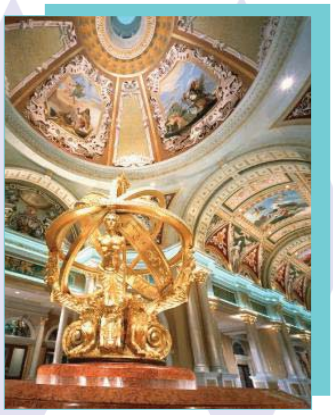
Chicago area.

Please call 847-945-6748 or fax resume to 847-573-8940.

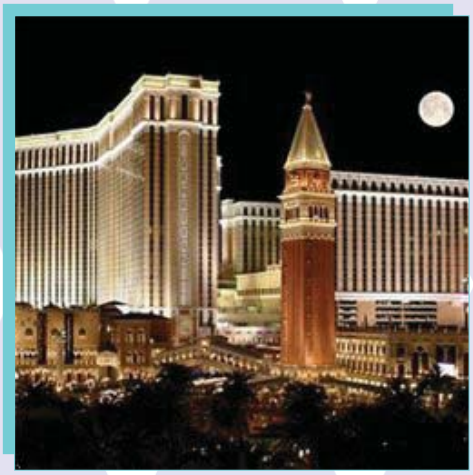
Odds are you won't want to miss the 15th Annual Scientific Meeting of the ISHRS

September 26–30, 2007

The Venetian ♦ Las Vegas, Nevada



Using Bio-Science and Technology to Evaluate, Refine, and Update Hair Restoration Techniques for Optimum Patient Safety and Cosmetic Outcome



Program Features

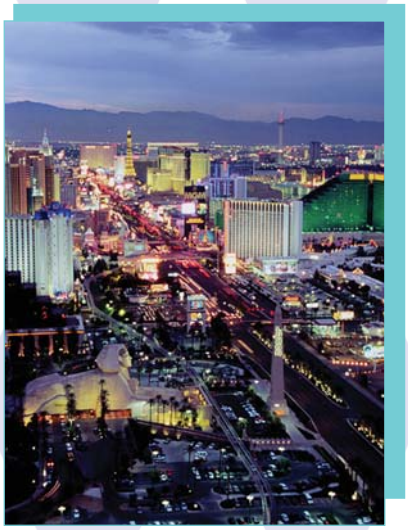
- Back by popular demand! Live Surgery via Satellite Session
- Basics in Hair Restoration Surgery Course: *Includes 9 hours of lectures on CD-ROM*
- Advanced Seminar
- World-renowned Featured Guest Speakers
- Peer Networking and Discussion Forums
- Surgical Assistants Program: *Full-day program with evening hands-on Cutting/Placing Workshop*
- Morning Workshops: *Interactive, small-group settings*

Call for Abstracts deadline:
February 10, 2007

VEGAS '07

ISHRS 15th Annual Scientific Meeting

September 26-30, 2007
The Venetian, Las Vegas, Nevada, USA



For more information, go to

http://www.ishrs.org/15thAnnualMeeting.html

Advancing the art and science of hair restoration

Upcoming Events

Date(s)	Event/Venue	Sponsoring Organization(s)	Contact Information
Academic Year 2006–2007 *Registration before* October 20, 2006	Diploma of Scalp Pathology & Surgery University of Paris VI— School of Medicine *Paris, France*	Coordinators: P. Bouhanna, MD, and M. Divaris, MD Director: Pr. J. Ch. Bertrand	Tel: 33 + (0)1 + 42 16 12 83 E-mail: marie-elise. neker@upmc.fr
March 7–10, 2007	13th Annual Live Surgery Workshop *Orlando, Florida, USA*	International Society of Hair Restoration Surgery Hosted by Matt L. Leavitt, DO	Valarie Montalbano Tel: 407-333-4200, ext. 141 Fax: 407-333-2140; 407-333-9464 *HValarieM@leavittmgt.com*
March 30–April 1, 2007	ISHRS Regional Workshop Asian Hair Surgery Workshop *Yokohama, Japan*	International Society of Hair Restoration Surgery Hosted by Kenichiro Imagawa, MD	Kenichiro Imagawa, MD Tel: 81-45-311-8811 Fax: 81-45-312-8866 *dr@yokobikai.or.jp*
May 24–27, 2007	10th ESHRS Congress and Live Surgery Workshop *Paris, France*	European Society of Hair Restoration Surgery *www.eshrs.com*	Tel: 00 33 1 45 00 00 76 Fax: 00 33 1 45 02 15 77 E-mail: eshrs@eshrs.com
May 31–June 2, 2007	XII ISHR International Congress *Milan, Italy*	Italian Society for Hair Restoration *www.ishr.it*	Assert Communication Tel: 39 02 43995 206 Fax: 39 02 4398 5241 *info@assert.it*
June 13–16, 2007	5th International Congress on Hair Research *The Fairmont Hotel Vancouver* *Vancouver, BC, Canada*	North American Hair Research Society *www.nahrs.org*	Congress Secretariat Simply Eventful Management Inc. Tel: + 1.604.738.8600 Fax: + 1.604.738.8697 *hair2007@simplyeventful.com* *www.hair2007.com*
September 26–30, 2007	15th Annual Scientific Meeting *The Venetian Hotel* *Las Vegas, Nevada, USA*	International Society of Hair Restoration Surgery *www.ishrs.org*	Tel: 630-262-5399; 800-444-2737 Fax: 630-262-1520 *info@ishrs.org*

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