INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

HAIR TRANSPLANT forum INTERNATIONAL

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COLUMNS

FEATURE ARTICLES

Orlando Live Surgery Workshop XIII: Advancing the Industry of Hair Restoration

Summing Up Day 1: Wednesday, March 7, 2007

Carlos J. Puig, DO *Houston, Texas*

This year, Drs. David Perez and Matt Leavitt brought together a faculty of skilled educators to present the Basics section of the annual Orlando Live Surgery Workshop. This planning combined with the exceptional administrative talent of Valarie Montalbano assured that the meeting will, once again, be one of the educational highlights of the ISHRS 2007 training season. The meeting was slightly smaller this year, making the faculty even more available for those personal interactions that create a strong educational experience for everyone.

Cutting station at the Live Surgery Workshop

After a brief welcome and orientation by Matt and David, the first two hours of the meeting reviewed the basic art and science of hair restoration surgery. Dr. Ricardo Mejia clearly summarized the etiology of hair loss and the anatomy of the hair follicle, nicely identifying to the group those aspects of anatomy and physiology that are most essential to the hair restoration surgeon.

Dr. Bob Leonard provided sound advice on structuring a responsible consultation, focusing on a thorough evaluation and setting appropriate expectations. Dr. Mike Beehner reviewed the design of an appropriate hairline, and offered very good advice to the novice hair restoration surgeon about how to keep the patient's hairline age appropriate. Dr. John Gillespie presented an excellent paper on the importance of painless anesthesia. He offered a modification of the liposuction tumescent anesthesia technique as a method of providing safe and sufficiently long-acting anesthesia by using large volumes of very dilute 0.2% Lidocaine with 1:500,000 epinephrine.

Dr. Marcelo Pitchon beautifully demonstrated with macro video photography his Long Hair Follicular Unit Transplantation, a process of transplanting follicular units without shaving the hair short. His video clearly demonstrated the advantages of transferring grafts with long hair, in that it helps the surgeon evaluate relative density. The surgeon can also enlist the opinion of the patient about the priority of areas to be covered. The technique helps the patient understand what the intended result in one year could be. He did point out that the long hair is but a tool used by the surgeon and the patient to communicate, because it will gradually fall out as usual during the first few weeks after surgery as the follicles go into their telogen phase.

Dr. Jerzy Kolasinski presented an excellent paper on assessing the donor area, both for surgical risk and availability. He presented a method of measuring vertical elasticity in order to assess the risk of a wider donor excision. He pointed out that clinical experience does not let one conclude that more scalp elasticity guarantees better scars. Indeed, too much elasticity may result in wider scars as well, and he suggested that two layer closures should be considered in both tight and excessively lax scalps.

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President's Message

Paul C. Cotterill, MD *Toronto, Ontario, Canada*

Moving the Field Forward


Paul C. Cotterill, MD

I am pleased to report that at the last ISHRS Board of Governors meeting recommendations of the Joint Task Force on ABHRS/ISHRS were unanimously approved. What does this mean?

The American Board of Hair Restoration Surgery (ABHRS) came into existence in 1995 for the purpose of having an examining body pertaining to hair restoration surgery. This board, although made up of members of the ISHRS, was a totally separate entity. There was some initial negativity toward the ABHRS by some of the ISHRS members, as the ABHRS is not recognized by the American Board of Medical Specialties (ABMS).

In 2005, the ISHRS conducted a survey of its members who were not ABHRS certified in an effort to obtain a better understanding of the membership's view on the issue of HRS board certification. The survey yielded a 30% response rate. Of 166 respondents, 70% felt that board certification is important to the specialty of hair restoration surgery; 72% indicated they would like to be certified in hair restoration surgery; and 90% indicated the ABHRS is trying to serve the public and the profession. Some of the reasons given against board certification were that hair restoration is a procedure and not a specialty, that many members are already boarded in other related areas, and that the ABHRS is not recognized by the ABMS.

The ABHRS now has over 100 members worldwide that are diplomates of the ABHRS. I should also mention for our international members that there is also an International Board of Hair Restoration Surgery designation. The ISHRS Board of Governors has followed the progress of the ABHRS over the past 10 years and recognizes its importance to our field. Some highlights of the recommendations of the Joint Task Force on ABHRS/ISHRS that were recently approved by the ISHRS Board of Governors are as follows:

1. A working statement to reflect the relationship between the ISHRS and the ABHRS, i.e., *"While there is currently no ABMS certification specific to hair restoration, the ABHRS is the only certification recognized by the ISHRS, the largest hair restoration educational organization in the world."*
2. The ISHRS will implement a new program, the ISHRS CME Award Program, within the next year. The CME criteria for this program will follow the template adopted by many ABMS specialties in regard to the Maintenance of Certification CME criteria. The designation "ISHRS CME Award < year > " will be listed after the member's name in the membership directory and on the website for those who earn the award. Please see Table 1 for criteria.
3. The designation "Diplomate—ABHRS" will be added next to the applicable physicians' names in the membership directory and on the website.
4. The ISHRS will develop an annual board review course that will reflect the core competencies developed by the ISHRS.

The ISHRS and ABHRS realize that a certification in HRS that is recognized by the ABMS would be difficult, and perhaps unobtainable, but nonetheless, a very worthwhile goal to try and achieve. Efforts have been and will continue to be made to work toward this goal. Meetings and discussions have taken place with members of the ABMS board as well as with the American Board of Dermatology (ABD) board for possible collaboration toward this effort. Thus far, the major obstacles to obtaining this designation include the perception (opinion of many) that hair restoration surgery is considered to be a procedure rather than a field, and that there is not a residency in HRS.

Obtaining Primary Board status is more challenging at this time. There is a possibility to work toward acceptance of a Subspecialty Certification that would

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Co-Editors' Messages

Robert S. Haber, MD *Cleveland, Ohio*


Robert S. Haber, MD

I had a very scary morning recently, which I'd like to share with you. My patient was a healthy 52-year-old woman about to undergo a 2,000-graft session. She was on no medications and gave a history of a brief episode of atrial fibrillation 20 years ago. The donor area was anesthetized with 15cc 0.5% lidocaine with 1:200,000 epi and 7cc 0.25% bupivacaine. Near the conclusion of donor anesthesia, she experienced severe central chest pains with no radiation.

Her pulse was 72 and irregular and blood pressure was slightly elevated. She was not short of breath. I immediately put her on oxygen and called 911. Paramedics responded, and an on-site ECG revealed ST depression. She was taken to the emergency room, where cardiac enzymes were slightly elevated, but a repeat ECG was normal. A second set of enzymes revealed further elevation, and she was scheduled for a cardiac catheterization the next morning.

I visited her in the hospital that evening, where for the first time she stated that she was very sensitive to epinephrine, and had experienced unpleasant reactions in the past, although not with chest pain. She refused her cath the next morning and went home, where she saw her personal physician. A cath was performed later that week, revealing no blockages, and a healthy cardiac output.

Her cardiologist ultimately concluded that she was indeed hypersensitive to epinephrine, and that coupled with anxiety, she experienced the equivalent of a stress test with temporary ECG and enzyme changes.

Just a few days later, the California media reported the death last year of a man undergoing a hair transplant, reportedly due to "anesthesia overdose."

A brisk discussion took place amongst my colleagues regarding these events and the more general topic of emergency preparedness. Should we be certified in ACLS? Or have an Automatic External Defibrillator, oxygen, and be prepared for basic life support? The answer depends on your location and paramedic response time, the degree of risk at your facility, your state or national guidelines, and your personal comfort level. At the very least, you should not be lulled into a false sense of security that the overall safety of hair transplantation is such that you do not need to be prepared. Even with healthy patients, rare drug interactions or unexpected health crises can and do occur.

The standard of care demands that you and your staff be prepared for any emergency; know how to activate an emergency response system and administer basic life support until more advanced care arrives. You should practice your protocol regularly, but with any luck you will never have to put it to use.

Bob Haber, MD

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


Jerry E. Cooley, MD

Recently a debate erupted among colleagues over whether to offer surgery to young men with hair loss. As so often happens, the debate quickly became artificially polarized into two competing camps: "those who do" and "those who don't." Further discussion revealed how unhelpful this distinction was. "Those who don't" had different age limits (e.g., 24, 26, 28, 30) for determining when a patient was old enough, and "those who do" had different restrictions for determining which young men would qualify as candidates. It turns out that everyone had different ideas of what it means to be "too young."

The principles of bioethics can be helpful for doctors in the midst of very difficult decisions, such as deciding when a patient can be removed from life support. Likewise, I think they can assist us when considering the topic of hair restoration for young men. The principle of respect for autonomy, for example, states that the individual has the right as a rational agent to make informed, voluntary decisions about their health. In contrast, paternalism attempts to do determine what is best for someone else, and is particularly justified for children or the mentally incompetent. Respecting autonomy does not mean the patient is allowed to determine the treatment plan.

The principle of beneficence states that doctors have a duty to provide benefit to their patient. The benefits of a well-done hair transplant can be immense, whether for the recently divorced middle-aged man or the young man too shy to date or perform well at work because of his hair loss. The principle of non-maleficence states that we should aim to avoid harming our patients. In our situation, this means we seek to avoid the harm of an unnatural look with the progression of hair loss. Virtually all of our cases have the potential to be "harmful" with the progression of hair loss, and this risk is inversely proportional to age. Attempting to quantify this risk in each individual case is an important part of the surgical plan as well as the informed consent process.

The use of ad homonyms, emotional language, and straw men have no place in this debate. While we will likely always disagree with each other when discussing this controversial topic, we can dramatically improve the quality of the debate by defining our terms, avoiding logical fallacies, and basing our opinions on the principles of bioethics.

Jerry Cooley, MD

Guidelines for Submitting an Article to the Forum

- ✓ Send submission *AND* Author Consent Release Form electronically via e-mail to Robert Haber, MD, at HaberForum@aol.com
- ✓ Include all photos and figures referred to in your article as separate attachments in JPEG, TIFF, or BMP format. Be sure to attach your files to your e-mail. Do *NOT* embed your files in the e-mail itself.
- ✓ An Author Consent Release Form must accompany your submission. The form can be obtained in the Members Only section of the website at www.ishrs.org.
- ✓ Financial conflicts of interest with devices, pharmaceuticals, cosmeceuticals, etc. discussed in your paper must be disclosed at the beginning of your submission.
- ✓ Trademarked names should not be used to refer to devices or techniques, when possible.

Submission deadlines: June 10 for July/August issue; August 10, September/October; October 10, November/December

Notes from the Editor Emeritus

William M. Parsley, MD *Louisville, Kentucky* (*Forum* Editor 2002–2004)


William M. Parsley, MD

It's hard to believe that is has been almost 2½ years since Drs. Cooley and Haber took over the *Forum*. They have done a wonderful job and will be hard to follow. I think the secret of their success comes from their great chemistry. Both have told me separately that working with the other has made this tough job a pleasure. It reminded me how nice it was to work with Mike Beehner; and I am sure the same was true for Dow Stough and Russell Knudsen. I can only hope the next Co-Editors have the same relationship.

It still surprises me that we have such diverse approaches to the young male patient. Being perhaps too conservative, I generally do not operate on patients under 30 years of age. Occasional patient exceptions would have to have limited hair loss (particularly in the vertex), good donor hair, and abrupt borders of the baldness. However, some highly respected doctors will operate on young men as early as their late teens. The argument is that the young man is having his life affected very negatively by the hair loss, causing him to withdraw socially and having his grades deteriorate. So what is the best course? We really don't have the long-term follow-up that could give us these answers. Newer techniques, notably follicular unit transplantation, have only been popular for less than 15 years, certainly not enough time for effective analysis of results. Problems with using round grafts on young men with advanced balding have been observed by all of us too many times. Will follicular units avoid these problems? The answer will almost certainly be "sometimes."

Without surgery the vast majority of young men will adapt to baldness and begin to function normally with a little time and maturity, even though they may always wish that they had more hair. This won't be the case with the young men who were transplanted with a poor cosmetic result. If their donor sites eventually thin and miniaturize so will their grafts, creating a double problem; and if severe, this will create a sparse recipient pattern that may not exist in natural balding. As they often do in young, active patients, the donor scars may stretch and later become visible as the donor area thins. Some of these patients will become "cosmetic cripples" with devastating effects to their self-esteem and happiness. These problems unfortunately don't often resolve. So is it right or wrong to operate on young men with signs of extensive baldness? Do we deny them help at a vulnerable age or delay in order to make the best decisions for their long-term care? That will have to be answered by each of us until we have some long-term follow-up and honest reporting of our results. In the meantime, many of us will be satisfied to treat these patients with medications and psychological support, delaying the decision to operate until we have a clearer picture of their future; but there is no question this is one of the toughest dilemmas we will face in our careers. Anyone with strong opinions on this subject is invited to send a letter to the *Forum* editors.

This year is the inaugural year for the **ISHRS Annual Giving Fund (AGF)**. The purpose of the AGF is to support new initiatives, activities, and programs beyond what the ISHRS annual budget can currently support. The Society's programs have progressed at lightning speed, but unfortunately our finances have not. While the Society remains on solid financial ground, the AGF will help to offset the costs associated with implementing these new initiatives. Every direction you look, you can see our growth. Examples of future AGF-subsidized growth include improved website features and placement, publishing the *Forum* in color, improved member benefits at meetings, more internationally known speakers, new training programs, and better research funding to name a few. So far 22 of our 648 physicians have contributed, and we have already met 65% of our 2007 goal of $43,750. The contributions of these 22 members will benefit the entire Society, but it would be nice for others to lend their support as well. Please assess the importance of the ISHRS to your career and consider a pledge to this valuable program. There will be no arm-twisting, but any help, no matter how small, will be greatly appreciated. If you desire more information, please contact ISHRS headquarters.

On Friday, September 28, 2007, from 5:30–7:00PM during the Annual Meeting in Las Vegas, there will be a President's AGF Reception to formally kick off the program and explain the future goals and activities. This will be a great opportunity to network with your fellow ISHRS members and just have fun. For this inaugural reception, a modest fee of $50 per person will be charged to help cover costs. Members donating to the AGF at the Leadership Circle level (donation of $1,000/year for 5 years) or higher will receive two complimentary tickets to the reception. Please plan to attend this reception so that you can better understand the mission and importance of a successful giving fund. If we all get behind it, the sky is the limit.

I don't know how it slipped by with so little fanfare. Dr. Richard Shiell retired last fall, ending a hair restoration career spanning over 40 years. Few if any have been recognized as much as Richard. He has won the Golden Follicle and Manfred Lucas awards, served as *Forum* Editor—and had his hand in nearly every significant ISHRS activity; yet his worth to hair restoration goes far beyond what can be put on paper. In my career, I don't think I have ever seen anyone who loves and has stimulated this field as much as Richard. He advised and encouraged so many of us, yet didn't hesitate to "set us straight" if we started down the wrong road. While his practice has ended, his vast knowledge and passion are intact, so that many of us still count on him as a quick source of information. There is a phrase used in Australia termed "one off," meaning that only one was created and that there will never be another. Richard, your many friends wish you a long and healthy retirement. You are truly "one off" and will be missed.✧

President's Message

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be included under one or possibly several Primary Boards. We think that the Primary Boards that would oversee the Subspecialty Certification would likely be the fields such as Dermatology, Surgery, and/or possibly Family Medicine. If this was the case, then the issue arises in that only the named specialties could potentially be qualified for the Subspecialty Certification. At this time, it is thought the wisest and most prudent course of action is for the ISHRS and ABHRS to work together to build a sustainable infrastructure, looking to and implementing many of the principles of the ABMS and to continue dialogue with the ABMS. It is the hope that the successful joint collaboration of the ISHRS and the ABHRS will help to influence the ABMS to recognize and accept cosmetic fields such as hair restoration, which until recently have been under represented.

Another topic that I am excited to report on is the development of the ISHRS Regional Workshops. In wearing my hat as Chair of the Continuing Medical Education Committee, it has been a goal of mine to encourage and develop regional workshops outside of North America. I have just returned from Japan where I attended the ISHRS-sponsored Asian Hair Surgery Workshop in Yokohama, hosted by Dr. Kenichiro Imagawa. This three-day meeting with 42 attendees was a huge success thanks to the tremendous efforts of Dr. Imagawa. Dr. Jim Arnold was also in attendance and has written a review of the meeting for the *Forum*. It was notable in that over half the attendees were non-ISHRS members.

The benefits of these regional workshops are that the ISHRS can reach out to physicians who might not always be able to travel to our annual meetings and show and teach the superior work that is now being done. We can also show the many advantages of being a member of the ISHRS and as such attract new members to allow our Society to grow. It is very expensive to hold our large annual meetings outside of North America. Smaller regional meetings in international locations are more cost-effective, can attract local physicians, and encourage learning in a more one-on-one environment that may be more conducive to learning, especially with physicians where English is not their first language.

If you are interested in hosting a workshop in your country, please contact the ISHRS. We will make every attempt to assist you.

Paul C. Cotterill, MD
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Table 1. Criteria for ISHRS CME Award

The CME Award will last for 3 years before recertification is necessary. For those who earn the award, the designation "ISHRS CME Award < year > " will be listed after the member's name in the directory and on the website. It may also be used on the member's private website.

CME: per 3 years

1. At least 100 verifiable educational hours/credits* over 3 years, of which at least 50% must be specifically hair related (activities sponsored by the ISHRS are recommended)
   a. American members
      1) All 100 credits must be AMA PRA Category I Credits (i.e., from programs approved under the auspices of the Accreditation Council for Continuing Medical Education, the ACCME) or AOA equivalent.
      2) At least 50% of the above hours must be ISHRS-sponsored Category I hair related credits or AMA PRA Category I Credits (or AOA equivalent) that are directly hair related.
      3) The remaining 50 (or less) hours may be any AMA PRA Category I Credits or AOA equivalent.
   b. Non-American members
      1) At least 30 hours must be ISHRS-sponsored Category I hair-related credits.
      2) The remaining credits (in order to reach 50 hair related hours) may be any AMA PRA Category I (or AOA equivalent) hair-related credits or any hair related hours from programs put on by member societies of the Global Council of Hair Restoration Surgery Societies** (the ISHRS is included in this Council).
      3) The remaining 50 (or less) hours to reach the needed 100 hours must be verifiable educational credits (hours) that may or may not be hair related.
2. At least one ISHRS Annual Meeting must be attended (this is required for both Americans and non-Americans).
3. In addition to (2), another ISHRS-sponsored hair-related meeting must be attended (this may include another ISHRS Annual Meeting).

* Program must provide documentation of attendance and hours (and content if being used for hair related credits). Credits and hours are synonymous in this context.

** See ISHRS website at www.ISHRS.org for list of member societies.

CME: Continuing Medical Education
ISHRS: International Society of Hair Restoration Surgery
AMA PRA: American Medical Association Physician's Recognition Award
ACCME: Accreditation Council for Continuing Medical Education
AOA: American Osteopathic Association