HAIR TRANSPLANT forum INTERNATIONAL

INTERNATIONAL SOCIETY OF ISHRS HAIR RESTORATION SURGERY

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COLUMNS

FEATURE ARTICLES

"Focal dense-packing" in hair transplantation

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

For the past four years, in many of my hair transplant procedures, I have been using a concept I refer to as "focal dense-packing." This refers to the filling in of a localized zone, usually around 2.5–3 cm^2 in area, located in a key visual area just behind the front hairline. In this small zone, I personally densely pack 2-hair FU grafts using a "stick-and-place" method. This procedure is described below.

Indications

There are four special indications in which I virtually always use this technique:

1. *All female patients.* The biggest complaint most females present with is that the scalp can be seen through the front-central hairline as someone views them from the front or side. For this reason, it is beneficial to select out a small "frontal core" circle, which starts around 0.5–1cm behind the edge of the front hairline, and fill it with 110–150 2-hair FUs (Figures 1 and 2).
2. *Males with deep fronto-temporal recessions.* These patients usually have a fairly strong frontal tuft in the front-center, but are thin or bald in the recessions laterally. I usually draw a somewhat obliquely oriented elliptical zone on each side, just behind the front hairline zone. This can be done at the first session, or, as is more often the case for me, at a follow-up transplant procedure. Both sides are usually done at the same time, requiring around 260–300 FUs in total. Occasionally, there will be a disparity of density between the two sides after the first or second surgery. In such instances, performing focal dense-packing on the thinner side helps that area "catch up" to that of the other side. Most of the time, such a disparity in apparent density is due to the original presence of more native hair on the stronger side.

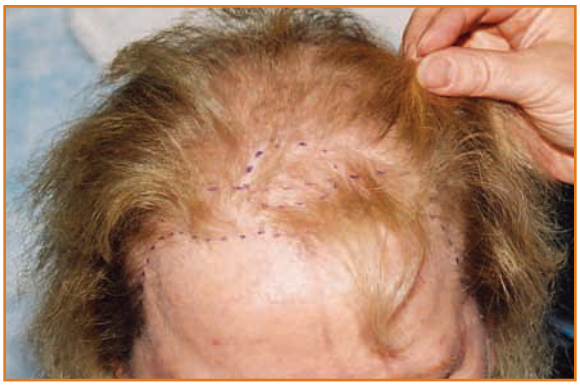

Figure 1. 49-year-old female with small "frontal core" area drawn in. 110 × 2-hair FUs placed in 19g sites in frontal core zone, along with regular transplant session around it.

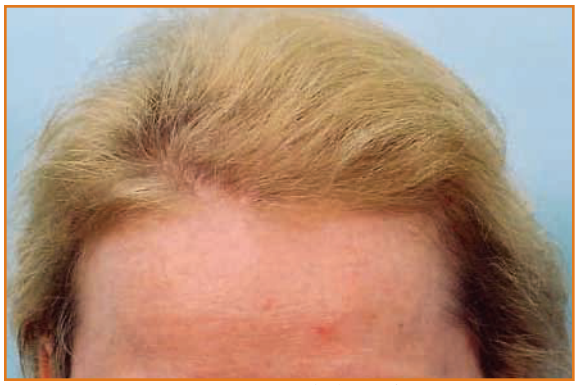

Figure 2. Same patient, 1 year 11 months later, after one session.

3. *Difficult "cow-lick" areas in front.* Where there is a sharp demarcation in direction of hair at the hairline, the area where the divergence occurs has a tendency to look sparse, even after 2–3 sessions (Figures 3, 4, and 5). Stick-and-place with a 21g needle enables the surgeon to place many FUs in this area atraumatically, with the least chance of "cutting the legs off" the other grafts that are aligned almost in a "V" configuration subcutaneously.
4. *Patient complaint area.* Whenever a patient returns for a subsequent procedure and there is a fairly localized area that he or she notes that they wish were denser, I will use this technique to address their area of concern. I feel this gives me the maximal chance of making that patient happy with the final result.

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President's Message

Bessam K. Farjo, MD *Manchester, England*

A few days ago I came back from Cancun, Mexico, where the ISHRS Board of Governors and past presidents met for our 2007 strategic planning meeting. You will remember the last time we had such a meeting was three years ago following which the Society embarked on initiatives to facilitate education and training for doctors and assistants, increase public and professional awareness of what we do, as well as establish financial security for the ISHRS.

This year's gathering was just as eager and energetic, but our facilitator, Mark Thorsby from the Smith Bucklin Corporation, agreed we were more experienced and focused in our goals and aspirations for the next few years of our Society's future. After reviewing the activities over the past three years and the findings of our 2007/2008 members' needs survey, passionate discussion and debate revolved around issues such as:

- where in the world new members will come from;
- language barriers;
- difficulties facing doctors wanting to enter the field;
- maintaining value for our members;
- how much of a role the ISHRS should play in training assistants;
- public relations for the benefit of the Society and its members;
- the structure, image, and marketing of the ISHRS website;
- the ISHRS's role dealing with new scientific breakthroughs and emerging technologies; and
- the financial implications of our initiatives and long-term financial security.

Over the next month or two, the Executive Committee and the Board of Governors will crystallise the findings from this meeting and agree on a strategic plan for the ISHRS for the next three years. In the meantime I welcome any input or comments from you about any issue or concerns you may have.

Speaking of the 2007/2008 members' needs survey, there were some interesting figures to come out of it. For example, 92.1% of physicians and 97.1% of assistants were either "very satisfied" or "satisfied" with the ISHRS Annual Meeting overall; 91% were either "very satisfied" or "satisfied' with ISHRS membership; 90.1% thought the ISHRS was "very effective" or "somewhat effective" in achieving its CME purpose; 80% thought the ISHRS was "very effective" in providing information news and development while 70% said we were "very effective" in providing opportunities for education and networking. Finally, it was very pleasing that 95% would recommend ISHRS membership to a colleague.

The day before the Cancun meeting, I was privileged to represent the ISHRS at the Allied Organisations Council of the Hair Foundation. Invited were representatives from groups concerned with hair and hair loss, hair research, cosmetology schools, hair colorists, hairpieces, alopecia areata, cicatricial alopecia, childhood leukemia, and others. You will be hearing a lot more about this in the future but what is certain is that everyone realises there is a great opportunity for all of us with interest in hair to work together for the public promotion of hair health awareness and who people can turn to for help.

As we welcome in 2008, I wish you all a peaceful and prosperous new year.

Dr. Bessam Farjo

Co-editors' Messages

Robert S. Haber, MD *Cleveland, Ohio*

It is with mixed emotions that I write my last message as *Forum* editor. Hard to believe that Jerry and I have had the helm for the past three years and 18 issues, and as I scan the pages of many of those issues I find it remarkable how much has transpired in that time. I am deeply grateful for the trust placed in me by my colleagues in allowing me the privilege of editing this extraordinary journal, and all the more appreciative of the great effort expended by my predecessors. I feel humbled to join the ranks of O'Tar Norwood, Richard Shiell, Dow Stough, Russell Knudsen, Mike Beehner, and Bill Parsley as a past editor. I am also relieved. Not just relieved that deadlines will no longer be my concern, but relieved that our replacements in Bernie Nusbaum and Paco Jimenez are more than up to the task of maintaining the high standards that we have attempted to preserve. It has been a true honor to share the editorship with Jerry Cooley, and in the past three years I've learned that I can rely on him for absolutely anything. And while Jerry and I get most of the credit, the *Forum* could not exist in its current form without the editorial and creative assistance of Cheryl Duckler and Victoria Ceh, to whom I am eternally grateful.

Of course, the pages of the *Forum* would be empty if not for the hard work of our columnists and members who take the time to share with all of us their ideas and insights. Thanks to all of you for your submissions over the past three years. In this, our final issue, we leave you with yet more surgical creativity from Mike Beehner, who discusses focal dense-packing, more words of wisdom from my dear friend Russell Knudsen, and a new view of an old topic—staples—by Bob Bernstein. We also learn a potentially life-saving lesson from Paul Shapiro, learn more tricks from Maurice Collins, gain analytical insights from Bill Rassman, on top of Pearls from Marcelo Pitchon and efficiency tips from Carlos Puig. Not a bad final issue. From the editor's standpoint, there's nothing as relieving as having too much for one issue, and I pass on several great submissions to be published by Bernie and Paco.

Keep all the great submissions coming. Remember, the *Forum* belongs to you, the readers. Only by sharing your triumphs, pitfalls, thoughts, and admonishments will this publication achieve the goals of education, of stimulating ideas and discussions, and of encouraging healthy debate and controversy.

Adieu.

Bob

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

It's hard to believe three years have come and gone. It has been a great honor and pleasure for me to work with Bob Haber as co-editor of the *Forum*. The previous teams of Knudsen/Stough and Parsley/Beehner seemed to have a synergistic chemistry that I am happy to say I believe I shared with Bob. Thanks, Bob for a great ride.

Bernie Nusbaum and Francisco "Paco" Jimenez-Acosta will no doubt do a splendid job of producing and editing the *Forum*. I can't imagine a better team to take over the reins. They will bring a new energy to the job, with a professionalism and thoroughness that will ensure each issue is the best possible. If anything, I am worried they will obsess a bit too much over each issue. But the readers will be the beneficiaries of this attention to detail.

This is a good time to acknowledge the other people who make each issue of the *Forum* come about. Cheryl Duckler is the layout editor and beautifully pieces together our submissions into a visually appealing and readable form. Victoria Ceh, along with Cheryl, proofreads each issue cover to cover with the same compulsive perfectionism she brings to everything she does. I would also like to thank all the columnists who contribute to the *Forum* regularly, giving us such features as Surgeon of the Month and Cyberspace Chat, to name a few.

Any acknowledgment has to include O'Tar Norwood and Richard Shiell. We should all be forever grateful that O'Tar had the vision in the early days to collect and publish the opinions of practicing surgeons. Richard took this simple newsletter and beefed it up to the journal style publication we know today. Richard is such a wealth of knowledge about hair restoration surgery that I consider him our walking encyclopedia. If you ever want to get an expert opinion about a new idea or trend in our specialty, ask Richard.

Finally, I would like to thank those who have taken time to submit their articles and ideas to the *Forum*. This is the essence of the *Forum*, its *raison d'etre*. It takes more than time and energy to do this. It takes a willingness to open oneself to scrutiny and criticism from one's peers. It is much easier to sit back and critique what others write. So I end by challenging everyone reading this to make at least one submission to the *Forum* in the next three years!

Jerry

ISHRS Regional Workshop

Asian Hair Surgery Workshop

Hosted by

Sungjoo Tommy Hwang, MD, PhD

May 4–5, 2008 • Seoul, Korea

The ISHRS is pleased to present this Regional Workshop hosted by Dr. Sungjoo Tommy Hwang on the topic of Asian Hair Surgery. Hair characteristics, head shape, hair and skin color, and other unique features specific to Asians will be discussed and techniques that can achieve optimal results will be demonstrated.

Faculty:
Jung-Chul Kim, MD, PhD
Seok-Jong Lee, MD, PhD
Paul C. Cotterill, MD
Alex Ginzburg, MD
Kenichiro Imagawa, MD
Damkerng Pathomvanich, MD
Sungjoo Tommy Hwang, MD, PhD

Limited Enrollment—Register Today!

Cost:
$1,600 USD for ISHRS members;
$1,800 USD for non-members

Registration:
Register online at www.registration123.com/ishrs/08AHSW/

For more information and to access the complete program:
Go to www.ishrs.org/asian-hair-surgery-workshop.htm or Contact Dr. Hwang by E-mail: doctorhair@naver.com or tommyhairdoctor@yahoo.com

Target Audience:
Physicians from beginners to advanced level of experience in hair restoration surgery.

CME Credit:
CME Credit will not be offered for this workshop, rather, a certificate of attendance will be issued.

Learning Objectives:
1. Differentiate Western FUT techniques from transplanter techniques.
2. Identify techniques that will achieve optimal result for Asians.
3. Recognize harvesting techniques with minimum hair transection and trichophytic closure.
4. Discuss methods to prevent or reduce the complications of hair transplantation in Asians.
5. Discuss the optimal method according to the degree of hair loss such as Norwood type.

ISHRS Regional Workshop
Asian Hair Surgery Workshop
Hosted by Sungjoo Tommy Hwang, MD, PhD
May 4-5, 2008 · Seoul, Korea

Guidelines for Submitting an Article to the *Forum*

- ✓ Send submission AND Author Consent Release Form electronically via e-mail to Bernie Nusbaum, MD, at drnusbaum@yahoo.com.
- ✓ Include all photos and figures referred to in your article as separate *attachments* in JPEG or TIFF 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.
- ✓ At the beginning of any article submitted for the Forum's consideration, authors must disclose any financial or other commercial interest they possess in an instrument, pharmaceutical, cosmeceutical, or similar device referenced in, or otherwise potentially impacted by, the article.
- ✓ Trademarked names should not be used to refer to devices or techniques, when possible.

Submission deadlines:
February 5, March/April 2008;
March 5, May/June 2008

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Notes from the Editor Emeritus

Russell Knudsen, MBBS *Sydney, Australia*

As we begin 2008, I thought I might offer a few thoughts on how we might all improve our practices in terms of marketing. The following thoughts are largely crafted in response to meeting patients who have been to other, reputable hair restoration practices but have had a less-than-satisfactory consultation experience.

A little while ago, a friend of mine who is intimately involved in marketing cosmetic surgery practices in Australia was chatting to me about my "clients." I gently pointed out that I don't have clients but I do have patients. My friend stated that this was just semantics. I respectfully disagreed. It really comes down to a state of mind. We are physicians, not retailers, and in an era where outcomes are affected by both medical treatment as well as surgical treatment, then our obligation is to take a holistic treatment approach for our patients and craft treatment options that are in their best interest.

So, I am continually surprised when patients for consultation tell me that, having been to other reputable clinics, I am the first person to mention Propecia®. Generally, they have been to a consultant, but not always. If you think that success is entirely determined by how convincing you are about the benefits of surgery alone, then you will be disappointed by your conversion rate. Even patients who are "sold" about the need for surgery want to find someone NOT desperate to operate on them, but rather be convinced that you are the person who understands how to take the long view and manage their problem in both the immediate and longer term. If you act like a physician rather than a salesperson, you will be delighted by the better communication and better trust you develop with your prospective patients. And by the better conversion rate.

I and many others have said this before: DO NOT overtly criticise your competitors. In Australia, or any first-world medical country, patients will not believe that yours is the only good clinic in the country! Give credit where it is due. This generosity to competitors mightily impresses the patient about both your credibility, and the lack of risk in them pursuing surgery in the first place. It is also wise not to make easily disprovable claims. Recently, a patient attended who had been told by a physician competitor that their clinic was the only one using microscopes. I said nothing but asked the patient to accompany me to the operating rooms. A single glance said more than a thousand words and instantly demolished any credibility for the other physician.

Patients generally do not react well to sales pressure. I am happy to acknowledge that I am a negative seller: the less keen (to a point) I seem to quickly sign them up, the more keen they are to choose me. Stay relaxed, calm, and sure of yourself with the patient. After all, they are consulting an expert and expect these non-verbal characteristics from you.

Lastly, especially to my North American colleagues, I ask you to consider the difference between a product and a service. A product may be sold by many retailers where the difference will only be in price. A service is unique and reflects the skill-set of the provider. Consider yourself service providers and try not to market on price alone. This demeans the service and leads some patients to believe that this is how they should choose the physician. In marketing, it is important to consider the concept of Unique Selling Point (USP). Our USP should not be our price but our skill and artistry. The product might be the modern follicular unit hair transplant, but the service is the skill and artistry with which it is designed and executed. If you want to add value to the service, raise the price. If you want to devalue the service, lower the price. I have heard recently of cut-throat price cutting that has driven some practices out of business because of lack of profitability. This is suicide, not good business practice.

The naturalness of modern follicular unit transplants means that our results are generally invisible to the general public. Patient satisfaction has never been higher. Our results sell themselves. It is time we all acknowledged that the average result from most surgeons is good and that the patient needs to choose a surgeon primarily on belief in the artistry and design skills that we provide. We do not need to oversell ourselves. Many patients are far more educated via the Internet than ever before. Have confidence that, after a comprehensive consult, the patient understands your professionalism and integrity. Your operating lists will improve.

Russell

Focal dense-packing
⇦ from page 1

My Method for Focal Dense-Packing

When I first started using this method, it was exclusively in females and I figured that using the maximal number of hairs per recipient site would give the greatest return in density. Therefore, I selected the 3-hair FU as my "work horse." I used all 3-hair FUs in the first 20–30 such patients, usually placing them in 18g needle sites (occasionally 19g for fine hair). I then held off doing any more cases until I could evaluate some of these patients 9–10 months later. To my surprise, I found that in over half the growth was very sub-par and disappointing. Figuring that perhaps the needle sites were too large and traumatic to the grafts' blood supply, I then switched to using all 2-hair FUs and placing them in smaller sites, using mostly 20g and 21g sites and only 19g when the patient's hair was coarse. I now use 21g needle sites for the great majority of cases. The assistants are instructed to pick out the best 120–150 2-hair FUs they can find. We refer to them as "tight two's," meaning that the hairs are closely aligned together and parallel without "teepeeing," and there are no miniaturized hairs present. Normally, we also seek to only use well melaninized hairs. If the patient has a natural blend of "salt and pepper" hair color distribution, then one does have to include some white hairs, to avoid this small circular area from sticking out as an abnormal swath of dark color.

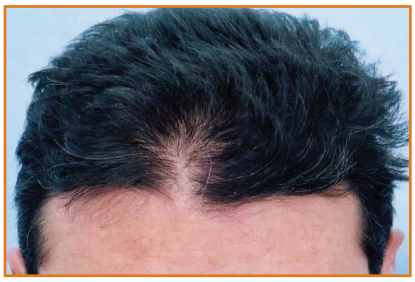

Figure 3. 42-year-old male with "cow-lick" of divergent hair direction in front-center.

Figure 5. Same patient, 1 year later, with cow-lick area filled in and less noticeable.

I mark off the intended focal area with a purple surgical pen, to help remind me not to place any of my pre-made incisions within those boundaries. When the pre-made sites are completed, I then obtain the selected 2-hair FU grafts from the assistants and do the stick-and-place procedure myself with 3 × magnification. Within the circular (or oval or elliptical) outline, I place each graft into the site just as the needle edge is prying open the site as it is removed. The needle is then used to stabilize the graft's placement so it doesn't slide out. I try to place the next graft in a different area of the small zone, rather than immediately adjacent to the most recently placed one, to help prevent "popping." A quick thrust of the needle helps to minimize popping of the nearby grafts. Before beginning the placement of these grafts, I inject a small amount of tumescent saline with 1:150,000 epinephrine with a 27g needle into the area. If one overdoes this, the fluid competes for the space that you want to place the grafts into. I keep jumping around from one part of this zone to another, gradually "filling in all the cracks" until I can't place any more. The density of planting is usually in the 40–60 FU per cm^2 range, depending on the caliber of the hair, because I can get much greater density using the 21g needles in patients with finer hair (Figure 6). Obviously, the diameter of the hair shaft is the biggest contributor to final maximal visual hair density, so the results are actually better with coarse hair at 40/cm^2 than fine hair at 60/cm^2.

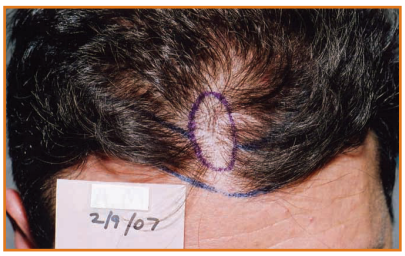

Figure 4. Small oval area filled in with 95 × 2-hair FUs in 20g and 21g sites, along with FU transplanting of surrounding area at lesser planting density.

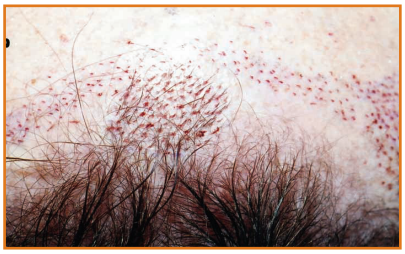

Figure 6. 125 × 2-hair FUs just placed in 21g and 20g sites within a 2.5cm^2 area in female patient.

General Comments

In contrast to my experience with the 3-hair grafts in mostly 18g sites, I have noticed almost uniformly excellent growth with the 2-hair FU grafts planted into smaller sites. The number of hairs I can fit into a small area is actually greater, simply because smaller needle sites can be used. I haven't used custom-made lateral slits for focal dense-packing yet, simply because I like the slight dilating affect that a needle provides to a recipient site. I find these sites help me to more atraumatically get the graft inserted. I feel strongly that the key to high survival of grafts placed very close together is the size of the recipient site. The smallness of the site, especially on the first "virgin" session, gives the surgeon tremendous leeway and freedom to pack densely, especially if the scalp is reasonably thick. Based on previous research studies of mine, I think this becomes less true on subsequent surgeries in the same area and in patients with noticeably thin scalps.

The obvious question someone might ask would be: Why not use this method to do the whole transplant? In 95% of my patients, I am addressing a fairly large area, usually the entire frontal and mid-scalp areas, along with the side temple areas in nearly half of these. I feel this is too large an area to use this technique on, in my opinion, for three reasons. First, I have serious doubts about the vascularity of the scalp supporting this type of dense-packing over a large area, even if the necessary grafts were available, and second, I don't want to take that much donor hair out at one time, risking a wide donor scar or telogen in the donor area from a tight closure. A third reason is that I prefer to make all of my own sites and not to delegate this task. I have come to the opinion that for smaller areas needing transplanting, such as patients who only need the frontal rim and temples filled in, "dense-packing" with lateral slits

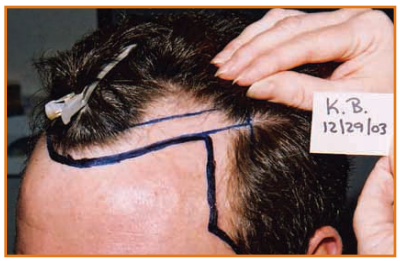

Figure 7. 39-year-old male desiring fill-in of frontal rim and temple areas. Dense-packing with lateral slits was used throughout the area, using 2,000 FU grafts.

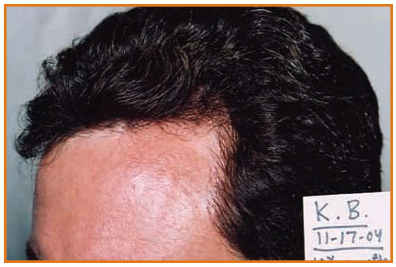

Figure 8. Same patient, 11 months later, after one session.

is the optimal way to proceed, usually requiring around 2,000 FUs in my hands (Figures 7 and 8). For everyone else, where a large area of the thinning scalp is being addressed, I believe it is wisest to back off a little in the density of graft placement and complete the project in 2–3 sessions. But, for this large group of people, I find it helpful to have this "focal dense-packing" tool in my armamentarium to create "instant density" in those small areas and instances when it is needed.✧