Surgeon of the Month: Tseng-Kuo Shiao, MD

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

Tseng-Kuo Shiao, MD
Overland Park, Kansas

Tseng-Kuo Shiao (also known as T.K.) was born in Taipei, Taiwan. He is the oldest of three children, and lived with his maternal grandmother until high school started. It was not uncommon for Chinese grandparents to help raise their grandchildren, and he felt lucky to have had the undivided attention of his grandmother.

T.K. immigrated with his family to the suburbs of Kansas City (United States) in December 1977 and completed high school in Overland Park, Kansas. Subsequently, he went to the University of Kansas and received his bachelor's and master's degrees in Computer Science. He proceeded to work a few years in the computer industry before going to the University of Kansas School of Medicine. The first ten years in the United States were difficult for his parents; his mother stayed here with the children while his father worked in Taiwan, but they willingly sacrificed themselves so their children could receive better educations and have better career opportunities.

T.K. was first introduced to hair restoration by his father and attended his first ISHRS meeting at Barcelona in 1997. Hair restoration, however, did not get his full attention until he started working extensively with him at his clinic in 2004. After working with his father for several years, T.K. found it a fascinating field with many great people, and started his own clinic, United Hair Restoration, in Overland Park, Kansas in 2007.

T.K.'s father, I-Sen Shiao, MD

T.K.'s father, I-Sen Shiao, MD, graduated from the National Defense Medical College, the oldest allopathic medical school in China with over a hundred years of history. He was a research fellow for artificial kidney in the department of Urology at University Hospital of Michigan during the early 1960s and later started the Pediatric department at the largest hospital in Taiwan. He started practicing aesthetic surgery in the 1980s and was the founder of the now 1,000-member strong Chinese Society of Cosmetic Surgery and Anti-Aging Medicine in Taiwan.

While seeking new developments in aesthetic surgery, Dr. Shiao had a chance encounter with hair restoration surgery during the International Hair Replacement Surgery Symposium at Hot Springs, Arkansas, in February 1986. T.K. can still remember the hundreds of turns through the winding mountain roads in Arkansas when they drove there from Kansas City: "My father was very impressed by the symposium's faculty and director, Dr. Bluford Stough." A comment made by the co-director, Dr. Richard Webster, on how techniques were taught freely, without reservation, how a father would teach his son, also made a lasting impression on his father. Incredibly, this has been the tradition at the ISHRS. The willingness of our members to teach and share experiences is unparalleled by any other field.

"Such novel experiences and dedicated teaching made my father focus his efforts on hair restoration. At an annual meeting in Los Angeles, Dr. O'Tar T. Norwood convinced my father to devote his efforts to mini-grafts and later to follicular unit transplantation. He became the first physician specialized in hair transplantation in Taiwan and has been exclusively doing hair restoration at his clinic since 1992."

"My father and I share similar philosophies in hair restoration. For my father, hair restoration is his hobby. It is personally rewarding when he creates art in every case and knows that he is helping people feel better. We see it as a form of art but we also explore what science and technologies have to offer to help better the art creation process.

"On a personal note, I have been married to a wonderful person, Chin-Hui Tseng, for over 20 years. We have one daughter, Jessica, who is 18 and a sophomore at Johns Hopkins University. My primary hobby is to explore the diversities in cultures and people through various types of personal encounters."✧

Review of the Asian Hair Surgery Workshop

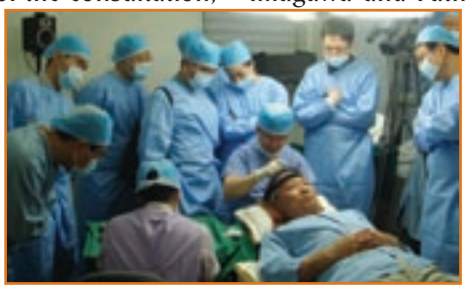
Paul C. Cotterill, MD *Toronto, Ontario, Canada*

This past May, Dr. Sungjoo Tommy Hwang hosted a very successful ISHRS Asian Hair Surgery Workshop in Seoul, Korea. This was the third Asian workshop and the second Korean workshop. The first Korean workshop was held in Daegu, Korea, in 2001 hosted by Dr. Jung-Chul Kim. The faculty this year included Drs. Paul Cotterill (Toronto, Ontario, Canada), Alex Ginzburg (Raanana, Israel), Kenichiro Imagawa (Yokohama, Japan) (last year's host of the Yokohama Asian Workshop), Jung-Chul Kim (Daegu, Korea), Seok-Jong Lee (Daegu, Korea), Damkerng Pathomvanich (Bangkok, Thailand), as well as our Korean host, Dr. Hwang.


(L to R) Drs. Sungjoo Tommy Hwang, Jung-Chul Kim, Alex Ginzburg, Kenichiro Imagawa, Damkerng Pathomvanich, Paul Cotterill, Seok-Jong Lee

The focus of the meeting, similar to last year's meeting in Japan, was to give Asian doctors exposure to current hair restoration techniques and advances as well as to showcase the differences in approach to Asian patients while incorporating the best from the West. Dr. James Arnold, who passed away last year, was at last year's Asian meeting in Yokohama and wrote a very insightful description of the meeting and covered many of the differences in the approach to Asians that were highlighted this year. I would urge the reader to revisit Jim's write up in last year's *Forum* (Vol. 17, No. 3; p. 94) as his coverage, in typical James Arnold fashion, was eloquent and comprehensive.

Both mornings began with didactic lectures. In my lectures, I covered many of the essentials of the consultation, including the approach to the younger patient as well as the management of the female patient, while Dr. Ginzburg covered key points on how to deal with the recipient area. Similar to last year, comprehensive presentations on the differences of Asian hair and, correspondingly, the differences in the approach and surgical treatments of the Asian patients were given by Drs. Imagawa, Pathomvanich, Hwang, and Kim. Dr. Lee's presentation on mimickers of androgenetic alopecia, and on scalp diseases that are not to be treated with surgery, provided important points to cover for physicians of any level of expertise.


Live surgery operation performed at Dr. Hwang's office

Highlights of the morning sessions included patients that the faculty selected for discussion on the management of Norwood types II–IV. This was followed the next day with discussions on Norwood type V–VII patients. The faculty was put to the task as to how they would treat each patient while at the same time including the audience in the decision process. This format worked very well and proved to coax much participation from the attendees. Another morning highlight was on the second day when Dr. Hwang, during a session entitled Live Patient Viewing, brought back the surgical patient from the day before for all to inspect along with six other of Dr. Hwang's previous transplant patients.

At the end of each morning we were bused to Dr. Hwang's state-of-the-art surgical facilities. Dr. Hwang's offices were perfect for hosting two simultaneous surgeries where attendees could observe bedside or in an adjoining lounge with live video feed. Dr. Hwang's attention to detail was very evident.

On the first day, Drs. Kim and Hwang transplanted a 29-year-old male with Norwood type II male pattern baldness (MPB) that had an unnatural hairline done in a previous first session elsewhere. Using the KNU implanter, 1,500 grafts, approximately 2,700 hairs, were transplanted. This is where the biggest difference between the surgical treatment of Asian and Caucasian hair is readily apparent. Due to the unique Asian hair characteristics of lower density, larger diameter, and dark, straight hair, grafts are quickly and efficiently trimmed without magnification and loaded into Choi or, in this case, KNU implanters. I am always amazed and impressed at how this particular technique of working from front to back and left to right, in fairly rigid rows, achieves a consistently natural result. In the next room, Drs. Imagawa and Pathomvanich used the western method to jointly transplant a 49-year-old male with MPB. 1,400 grafts, about 1,800 hairs, were obtained with microscopic dissection. Dr. Pathomvanich employed his meticulous and time-consuming follicle saving technique of carefully excising a donor ellipse by visualizing every follicle. Traction, 3-4 skin hooks, 2 assistants, tumescent fluid, and a bloodless field with suctioning are all components. On day 2, Dr. Hwang transplanted a female with female pattern hair loss with 1,500 grafts (around 2,850 hairs). As well, a scar revision employing about 400 grafts was performed by Drs. Hwang and Pathomvanich. Dr. Ginzburg demonstrated his w-plasty technique on the donor scar. After that, Dr. Ginzburg attempted FUE just superior to the donor revision incision. However, the yield was less than expected, likely due to the poor tissue turgor and local effects created by the revision. Another highlight was Dr. Hwang bringing back the 2 patients from the day before to

see how the patients were doing, inspect their grafts, and wash their hair. This generated much discussion.

All surgeries were very well received. Dr. Hwang was a gracious host who really went out of his way to ensure a quality learning experience. In attendance at the meeting were 46 participants, not including faculty, from 14 countries: Korea (24), and the rest from Japan, China, Hong Kong, Singapore, Israel, Georgia, Turkey, Taiwan, Thailand, Canada, USA, India, and Malaysia. There were 22 ISHRS members and 24 nonmembers. The experience level ranged from 17 physicians at the advanced level, 18 intermediate, and 11 novice. I have had the privilege of being able attend all three ISHRS/Asian workshops and experience firsthand the incredible amount of talent and expertise our Asian members have to offer. I have also seen the great amount of interest and enthusiasm the attendees bring to the workshops. The facts that 1) over half the attendees were non-ISHRS members; 2) almost half of the attendees were from outside of Korea; 3) the meeting was over-sold; and 4) this is the second Asian meeting in 12 months, indicate that there is a big draw from Asia and surrounding countries with continued interest. Due to the logistics and costs of holding our large annual ISHRS meeting, North American venues are favorable for a meeting of that size; however, there are many doctors from around the world who appreciate the ISHRS bringing the educational activities to them. These smaller, more intimate workshops are unique opportunities for physicians to learn new techniques, and to also learn about the ISHRS. Hopefully, with more doctors like Dr. Hwang, who has put a tremendous amount of time and effort into ensuring a successful workshop, more ISHRS/Asian regional meetings will be available in the future.

Melike Kuelahci, MD *Istanbul, Turkey*

The best thing about living in a world that's round is reaching the East if you continue going West. While the West promises a new world of opportunities and gold, the East is a symbol of wisdom, the traditional and the peaceful—and, in a world that's round, that should be the final destination for you to reach. Having attended the Orlando and Europe workshops for years, I decided that it was time for me to go to the East. To the Asian Hair Surgery Workshop, hosted by Dr. Sungjoo Tommy Hwang.

Attendees of the Asian Hair Surgery Workshop

Dr. Hwang opened the meeting, followed by Dr. Paul Cotterill, who gave a speech on behalf of the ISHRS. Founded in 1993, this Society, with its 746 members, is the biggest association in its field and its purpose is to promote professional excellence. Having served as a board member for six years, I listened to Dr. Cotterill with great pride. Even if we are heading towards the East in a personal state of peace, the idea of belonging to Western institutions is nevertheless assuring.

Next, Dr. Kenichiro Imagawa spoke on the differences between Asian and Caucasian patients; primarily that Asians usually have coarse black hair; mostly two-hair units (50-64%) and some three-hair units (13-17%). In my opinion, these numbers don't differ much from the typical Caucasian.

Dr. Cotterill then followed with comments on consultations and the approach to young patients, as well as nonsurgical treatments and female hair loss. He pointed out that cyproterone acetate is not available in the United States. This bewildered me. In a country where estrogens are still being sold despite their carcinogenic effects being well known, why are antiandrogens forbidden?

Dr. Damkerng Pathomvanich next gave a presentation on optimal hairline placement for Asians and showed us a laser device, described by him as the "instrument of the century." Applied first by Dr. Bertram Ng, it emits a criss-cross laser beam to create a variety of hairlines. Unfortunately, it is not yet on the market, but Damkerng, whose name was so difficult for me to pronounce (but I finally got it at the end), says that it should soon be available.

Dr. Jung-Chul Kim presented FU transplantation using the KNU implanter. The device is not new, but is widely used among Korean surgeons. I, on the other hand, prefer not to use the implanter because in the last few years, in my patient population, I tend to apply dense packed mega-sessions, with a regular density of 40 FUs per cm^2, which, in my opinion, is difficult to achieve with the implanter. Dr. Kim gave two other lectures; one on good and bad candidates for HTS and the other on the approach to young patients. I think that the number of presentations on the latter topic constituted an all-time high at this workshop—maybe there is a generation gap that we have to deal with, after all.

Next, Dr. Alex Ginzburg, my good friend and neighbor from Israel in my part of the world, gave a wonderful summary of recipient sites with different kinds of instruments currently available in the market.

The best presentation for me was that of Dr. Pathomvanich explaining the technique of donor harvesting with minimal transection using skin hooks, a technique that I would definitely try in my own surgeries. I think this method would diminish most patients' complaints about scalp hypoesthesia after surgery due to sparing of nerves and vasculature.

The last speaker of the day, Dr. Hwang, gave a presentation on complications and their prevention in hair surgery. For the purpose of increasing awareness of potentially disastrous results, this talk was absolutely necessary.

During the course of the day, we went to Dr. Hwang's office and observed two live surgery operations. Dr. Hwang and his two assistants organized everything—the cameras and the sound system worked in perfect harmony.

The last day of the meeting we toured Seoul and explored its famous Korean treasures. This city, with its 15 million people and its metropolitan skyscrapers that have only been created in the past 35 years, is nothing less than impressive.

On the flight home, I felt grateful for being a part of this round world. ✧

Review of

Made in Italy: Hair Restoration Live Video Surgery Workshop

Made in Italy: Hair Restoration Live Video Surgery Workshop
Rome, Italy • Msy 30–June 1, 2008

Melike Kuelahci, MD *Istanbul, Turkey*

Dr. Piero Schiavazzi opened the meeting with a talk on the 10-year history of hair restoration meetings in Italy and emphasized the importance of public awareness in state-of-the-art hair restoration. Dr. Schiavazzi's title is not from a medical degree, rather, he is a prominent journalist, interviewing leading politicians all over the world. His enthusiasm for hair transplantation began 10 years ago when he was the recipient of a hair transplant, which made him strive for getting the word out about this field.

Rome Workshop Program Co-Directors: Drs. Ciro De Sio and Robert T. Leaonard, Jr.

Dr. Robert Leonard, in his speech "Transitions to the Latest Trends in Hair Restoration Surgery," reviewed the history of our field, beginning in the late 1930s with the work of Dr. Okuda in Japan, and chronicled hair transplantation through the past 70 years. Dr. Leonard then described the "plug" technique followed by "split grafting" and donor area closure. Next he described follicular unit (FU) transplantation and follicular unit extraction techniques. He concluded with discussion of non-surgical treatments of male and female pattern hair loss as well as hair cloning.

On the first day, two surgeries were performed. Dr. Franco Buttafaro started with a frontal baldness case with approximately 2,300 FUs. He worked with his own team and used a density of about 20 FUs/cm^2.

Next, Dr. Ronald Shapiro's surgery was structured on a basic density of 30–35 two-to three-hair FUs per square centimeter with spikes on a wavy hairline. His mixture of two hairs with ones was worth mentioning. In the center of each irregular-sized spike, Dr. Shapiro inserted a bunch of two-hair FUs and than spread one-hair FUs around using stick-and-place. Using 0.7–0.8mm blades obtained from custom cut razor blades, he made sagittal slits, except in the temples where he turned to coronal again. Both surgeries were broadcast to a press conference where Dr. Schiavazzi moderated a question-and-answer session. The aim was to give more information to the media about refinements in hair restoration surgery and an idea about future therapies such as hair cloning.

Dr. Paul Rose performing surgery, assisted by Veselina Jelisavac and Karl Moser of the Moser Clinic.

After lunch, Dr. Ciro DeSio and Dr. Leonard removed a Frechet Extender after 3 weeks and performed a triple flap. In the second operation theater, Dr. Robert Haber excised a strip in 10 seconds using the Haber extractor, and worked with SAG slits on a female patient.

Saturday included two panel sessions. First was "Hair Research: A Growing Topic," moderated by Dr. Kenneth Washenik. Dr. Washenik, who has been working actively in recent years for cell biology and tissue engineering for Aderans Research Laboratories, described recent updates. Dr. Bessam Farjo reported on the" dermal papilla (DP) alone strategy", where DP cells are used to recruit keratinocytes from interfollicullar epidermis. Keratinocytes can form follicle cell aggregates—"proto-hairs". The expected next step is to make use of proto-hairs in human volunteers. Next, Drs. Liudmila G. Korkina, a cell-biologist, and Walter Krugluger presented their own concepts on how to induct new follicles. Specifically, Dr. Korkina improved the expectation of clinicians with her enthusiastic "very soon" promises.

After the coffee break, Dr. Schiavazzi moderated a panel with three journalists: one from Men's Health USA, one from the London Times, and one from the most widely read Japanese newspaper, Shimbun (18 million copies). This panel was paid for personally by Dr. Schiavazzi because of his strong conviction that hair restoration doctors are producing the best and most undetectable transplants but the public has no idea of what we can achieve. In fact, we are our own worst enemies—because the results are so good and patients don't talk about the fact they've had a hair transplant, so the public thinks that we still do plugs as they only see bad, outdated results.

The panel directed by Dr. Leonard, "Overview on Current Non-Surgical Treatments," discussed the current treatments of male or female pattern hair loss including Propecia®, Rogaine® Solution and Foam, and Low Level Laser Light Therapy. Desanka Raskovic described also the use of serenoa repens—which is simply the Latin name for saw palmetto. Two things about minoxidil were "off record" but important observations: 1) at the 5th week of treatment hair shedding peaks for a couple of days, and 2) minoxidil is more effective than thought in the frontal area and temples. The next speaker was Dr. Joe Greco, who discussed platelet therapy and presented his evidence-based study with nice pictures showing faster healing of scalp crusting and erythema.

After lunch, half of the attendees viewed the live surgery via video connection in the conference hall while the other half rotated through the surgery rooms. Five procedures were done in parallel, covering such topics as vertex, hairline, FUE combined with FUT, hairline correction, and hairline thickening in a second operation. With respect to the FUE combined with FUT case, note that it would be very difficult to do both on the same day because of the edema and the hair roots changing direction.

Robert T. Leonard, Jr., DO *Cranston, Rhode Island*

Following the typical Italian traditions of hospitality and generosity, the workshop began with a special guided visit to the Capitol Museums and a welcome at the Pietro da Cortona Hall on Rome's Capitol Hill. Next, the entire delegation of attendees was hosted to an unforgettable dinner at the home of Dr. and Mrs. Ciro DeSio, offering several courses of delicious dishes prepared by Cinzia DeSio. A huge grazie mille to the DeSios!

A highlight of Friday's program was the simultaneous video transmission from the operating rooms of Drs. Ron Shapiro and Franco Buttafarro both to the audience of medical attendees and to a group of journalists from throughout Italy and the world during a Press Conference organized by Dr. Piero Schiavazzi. The afternoon's live video feeds were from the operating rooms of Drs. DeSio and Leonard (triple flap procedure) and Dr. Robert Haber (female restoration). The evening was topped off by a marvelous dinner, al fresco, in the Travestere neighborhood of Rome.

Highlights of Saturday's program included the Surgical Assistants and Nurses Program, organized by Dr. Maurice Collins with the invaluable assistance from Joanne Scannell, RN, and Dr. Jennifer Martinick. A packed house of hair transplant assistants received an overview of anatomy, vocabulary, transplant and graft preparation techniques, common medications, and emergency management in hair restoration surgery by this most capable faculty. The other portion of the day's program was the Panel on Media Training, where roles were reversed with the journalists in that they took questions from the physicians about topics important to a hair restoration surgical practice. The afternoon allowed attendees to directly observe and interact with surgeons performing their procedures in state-of-the-art operating rooms of the IDI and it included the following surgeons: Drs. Marco Toscani, Kenichiro Imagawa, Paul Rose, Robert Leonard, Jean Devroye, Jerzy Kolasinski, and Luigi Belliazzi. The evening concluded with the elegant Gala Dinner at the Casina Valadier in Villa Borghese Park.

Sunday brought together many physicians who put into practice the topics of the lectures given in the morning on the subject of the hair loss consultation by Drs. Jennifer Martinick, Robert Leonard, Ciro DeSio, and Salvatore Marrocco. Approximately 50 Italian citizens came to the IDI to be examined by our faculty, which included Drs. Devroye, Belliazzi, Imagawa, Koher, Marrocco, Mollura, Rose, Niedbaldski, M. Unger, Buttafarro, Farjo, Haber, Leonard, Kolasinski, Martinick, Shapiro, Toscani, and DeSio. These complimentary consultations on men, women, and children suffering from hair loss offered the opinions of world-renowned hair restoration surgeons as well as provided a hands-on learning experience for attendees—both novice and experienced in the field. Immediately following the adjournment of the conference, Dr. Piero Schiavazzi arranged a "cook's tour of the kitchen" with a guided tour of the magnificent St. Peter's Basilica as well as a moving experience beneath the church into the grottos and burial place of Pope John Paul II and many other popes.

Attendees and staff at St. Peter's Basilica

I also want to thank the faculty who traveled from near and far to participate and make this workshop a resounding success. A great big grazie to all at the IDI from the President to Dr. Piero Schiavazzi and their excellent team including Dr. Giuseppe Aleo, Dr. Alessandro Franconetti, Ann Anthony, Flavia Sinatra, Agnese Cacciana, Alessandra Cacciani, Linda Fioroni, Giorgia Lattanzi, and Debora Bora. Thank you, too, to Liz Rice-Conboy and Kimberly Miller from the ISHRS headquarters. Much gratitude also goes to all of the assistants and nursing staff who helped to make the surgical portion of this meeting so great, with special thanks to the Moser Group who provided a large number of assistants for this meeting. To our patients, we must offer our humble and sincere thanks for being available to teach us all. Finally, from the bottom of my heart, I wish to congratulate and thank our own Victoria Ceh for organizing and triple-checking all aspects of this meeting allowing it to be as wonderful as it was. Mamma mia, what a meeting!✧

Surgical Assistants and Nurses Program

Jennifer H. Martinick, MBBS *Perth, Australia*

Almost 30 attendees participated in the Surgical Assistants and Nurses Program in Rome, which was chaired by Dr. Maurice Collins, assisted by his registered nurse, JoAnne Scannell, and Dr. Jennifer Martinick. The program was an excellent introduction to the basics of hair transplantation, such as planning and organization, graft preparation, keeping grafts alive, and patient management, including emergencies, medications, use of oxygen, and avoidance and management of complications.

Dr. Jennifer Martinick addressing the Surgical Assistants & Nurses Program, chaired by Dr. Maurice Collins.

Dr. Martinick spoke on the training methods used in her practice, including using her training boards and the importance of teaching staff to use the minimum number of movements to cut and place grafts. At the end of the program, Dr. Collins introduced a novel approach to learning, where he asked questions of the audience—a great way to reinforce the participants' learning experience. Dr. Collins pointed out that after being taught something, we only retain 50% by the next day, and only 5% after a month! A sobering thought.

Unfortunately, continuous translation was not available, so the workshop took longer than expected. However, this did not detract from the content and given the answers from the participants, much was learned.

As all the faculty was Irish born and bred, it was truly an Irish-Italian affair.

Fabio M. Rinaldi, MD *Milan, Italy*

The 13th Annual Meeting of European Hair Research Society (EHRS), held in Genoa, Italy, July 3–5, 2008, was organized by Alfredo Rebora and Marcella Guarrera. The meeting offered scientific presentations by researchers from Europe, Asia, and America, and included much useful information related to the biological and clinical understanding of hair diseases and hair transplants.

In the field of hair follicle biology, Michael Philpott (United Kingdom) presented very interesting data about premature senescence of balding dermal papilla cells (B-DPC) caused by loss of proliferative capacity of B-DPC *in vitro* associated with decreased expression of proliferating cell nuclear antigen and up-regulation of p16INK4a and nuclear expression of markers of oxidative stress and DNA damage. Premature senescence of B-DPC *in vitro* and the expression of these markers in DPC suggest that B-DPC are more sensitive to oxidative stress and to environmental stress than healthy DPC, and that this mechanism may be involved in androgenetic alopecia.

Photo from www.destination360.com

Informed by these results, I proposed a clinical trial on the impact of air pollution and oxidative stress on the hair follicle and scalp. In this study, involving 450 volunteers, we evaluated the effect of oxidative stress, mediated by ROS (reactive oxygen species) generated directly from particulate matter (PM 10, PM 2.5—specific environmental pollutants), which may be a mechanism of chronic inflammation of the scalp and generate a particular scalp disease called "sensitive scalp." In Milan, 41.3% of the 350 people living there (a polluted urban area) suffer from sensitive scalp, versus 13.6% of the 100 people living in a country area in North Italy (unpolluted area). This scalp condition may be an etiological factor for hair loss, and may present a problem for patients who undergo a hair transplant.

These data, together, can identify new pathways that could lead to alternative therapeutic strategies.

Desmond Tobin (United Kingdom) presented an update on melanocyte aging in the hair follicle: Is the hair bulb melanocyte the body's ultimate age sensor? The relevance of canities in humans remains unclear, as it occurs after reproductive peak age, suggesting it has no evolutionary selective advantages. He suggested that canities may be a threshold response to a combination of reactive oxygen species—associated damage to sensitive hair follicle melanocytes, impaired anti-oxidant status, and failure of melanocyte stem cell renewal. Tobin reported that melanin synthesis itself is a rather toxic business, generating much oxidative stress via oxidation of tyrosine/dopa.

Jae-Yoon Jung (Korea) presented a study about the efficacy of dutasteride in AGA recalcitrant to finasteride. He showed the clinical efficacy of 0.5mg a day orally of dutasteride in 31 men suffering from AGA who did not respond to conventional finasteride treatment. In 24 of these subjects, there was a significant improvement in hair density and thickness ($p < 0.001$). No serious side effects were reported, but 6 patients complained of transient sexual dysfunction.

In the hair restoration session, Marco Toscani (Italy) described a modified method to harvest intact hair follicles. He subdivides the single unit into two parts by microdissecting the follicle in the upper area to leave the bulge, and the lower containing the dermal papilla. These data support the evidence of the possibility to duplicate *in vivo* human hair follicles. This behaviour is likely due to the potential of the bulge cells to regenerate the lower portion of the follicle, whereas the dermal papilla is influenced by the surrounding environment through stimuli that still need to be identified. Duplicative surgery permits us to obtain a larger number of grafts, a natural appearance, and to reduce the scar in the donor site. The disadvantages, in the opinion of the author, are slower growth of hair and a longer procedure.

Andreas Finner (Germany/Canada) presented a study to standardize the surgical procedure of hair transplants using a digital imaging technique. In two different randomized pilot studies, he investigated hair growth in a target area before and after hair transplant, measuring donor hair density and calculating transection rates. Increasing the evidence in hair restoration will scientifically substantiate and validate the quality of hair transplants, improving this technique and thus benefiting the patient when they undergo the surgical procedure.

If you'd like more details on this educational meeting, please see the EHRS website at www.ehrs.org.✧

Review of the

Literature: Facial Plastic Surgery

Sheldon S. Kabaker, MD, Sumit Bapna, MD *Oakland, California*

The Transgender Patient

Citation

Spiegel, J. H. Challenges in care of the transgender patient seeking facial feminization surgery. *Facial Plastic Surgery Clinics of North America*. 2008; 16(2):233-238.

Jeffrey H. Spiegel describes the characteristics of the transgender patient and the challenges associated with surgically treating this difficult population. Facial feminization surgery (FFS) encompasses several procedures offered by facial plastic surgeons, including rhytidectomy, brow lift, cheek implantation, lip augmentation, scalp advancement, frontal cranioplasty, and reduction mandibuloplasty. Most commonly, transgendered women (women born as men but diagnosed with gender identity disorder) seek FFS. These patients lead difficult lives battling depression, rejection by family and friends, and alienation at work. Their ultimate goal is to pass as a woman 100% of the time, or achieve "stealth" status in order to live their lives as women without being identified as transgendered.

One of the challenges faced with patients seeking FFS is the expectation that the newly created face will not only pass for a woman but also have feminine beauty. They frequently desire a fantasy outcome. Emphasis must be made that the goal of the first surgery is to feminize and that future surgery can address beautification. Computer simulation of surgical outcome can be problematic also. Frequently, computer artists change facial features that cannot be surgically corrected, increasing expectations.

Other situations can also present difficulties in dealing with FFS patients. The Internet has allowed the transgender community to share unlimited information including when they are having surgery and with whom, who else they consulted, pricing, and pre-operative and post-operative pictures that are not taken by the surgeons. Physicians often hear comments about other patients' surgeries but privacy issues prevent them from discussing this. Also, the private chat rooms and online communities are password-protected, preventing access by surgeons. Physicians offering FFS must also learn to expect that patients possess a high level of information regarding the procedures. Variation in technique or philosophy from the two or three preeminent physicians in this field will be strongly questioned.

The use of names and pronouns can be sensitive to patients. The majority are deeply offended if called anything but their chosen female name or are referred to by "he" or "him." Education of the office, operating room, and hospital staff can be helpful for the environments that these patients will be in. Another challenge for dealing with patients seeking FFS includes the great distance that patients must travel for surgery. Finally, Spiegel describes that caring for transgender patients carries a high risk for physician and staff burnout.

The hair restoration surgeon is often consulted by these FFS patients. Most are on female hormone replacement therapy and some have had sex reassignment surgery. They are at low risk for further hair loss but unless they are Norwood Class I–III patterns, they are likely to be unhappy with a surgical hair restoration to achieve feminization.✧

Review of the

Literature: Dermatology

Marc Avram, MD, Nicole Rogers, MD *New York, New York*

A Hairy Hypothesis

Citation

Stenn, K.S., Y. Zheng, and S. Parimoo. Phylogeny of the hair follicle: The sebogenic hypothesis. *J of Invest Dermatol* 2008; 128:1576-1578.

A recent publication in the *Journal of Investigative Dermatology* set forth an interesting hypothesis for how hair follicles came into existence. Stenn et al. propose that the original purpose of the hair follicle was to serve as a wick to deliver lipid components from the sebaceous glands to enhance the overlying epidermal permeability barrier. As amphibious creatures made the transition to a predominantly terrestrial lifestyle, they required a more sophisticated epidermal barrier to protect against water loss. The sebogenic hypothesis proposes that organisms that could augment their epidermal barrier, using lipids produced by underlying glands, were better able to survive the harsh, dessicating environment on land. That primordial "wick" may have been a simple keratin plug, which over time has developed many layers. And as the hair grows out, it pushes the surrounding secreted lipids toward the surface.

There is evidence that the formation of the hair follicle and the sebaceous gland are very closely related. A weak hair-inductive signal will produce sebaceous glands without hair follicle formation, while a strong hair-inductive signal gives rise to both sebaceous glands and a hair follicle. With time, animals bearing this adaptation were better able to withstand a drying environment, through the use of this wick to deliver lipids to the surface. Furthermore, the modern-day hair follicle is also able to help protect animals from trauma, heat loss, and radiation.

Comment

The head continues to be an important source of heat and water loss. We wear hats during the wintertime to help protect us, and notice sweating when we are overheated. Our hair also protects us, not only from the sun's radiation but also to retain heat for our bodies. It is interesting to think that perhaps the hair was only a functional adaptation, allowing delivery of sebaceous lipids to the skin surface to prevent heat and water loss. Since then, it has grown to serve so many other functions, not the least of which is the cosmetic framing of the face and enhancement of our appearance!

Counting Hairs

Citation

Wasko, C.A., et al. Standardizing the 60-second hair count. *Arch Dermatol* 2008; 144:759-762.

When patients come in complaining of increased shedding, dermatologists and other hair experts reassure them that it is normal to lose around 100 hairs per day, but this value is theoretical, based on the theory that 10% of our 100,000 hairs are in telogen, and divided by the average length of the telogen phase (100 days), which equals 100 hairs shed per day. However, as Wasko, et al. point out, it is difficult for patients to accurately count hairs lost throughout the day. It is far easier to make a one-time, 60-second collection of hairs and to compare these to expected averages for other normal patients.

In this study, 60 men without alopecia, aged 20-60, were asked to use standardized combs, under standardized conditions, to assess their total hair count. They washed their hair on three consecutive days with T/Sal shampoo (Neutrogena). On the fourth day, before shampooing, they combed their hair for 60 seconds and recorded the number of shed hairs. The comb used was 15cm long and with teeth separated by 1mm on one half and 2mm on the other half. The men repeated this technique over 3 days, and then again 6 months later to account for any seasonal variation. Overall, the study found that subjects aged 20-40 shed an average of 10.2 hairs (range 0-78) per session, and patients aged 40-60 shed an average of 10.3 hairs (range 0-43). Patient-reported counts were confirmed by investigators.

Comment

Patients with hair loss can be further evaluated with the use of this simple technique. It may not be applicable to persons of different ethnicities, because African Americans were not included in the study; however, Caucasian patients with hair loss may find this helpful to diagnose telogen effluvium. Also, there may be some need to further refine the study using combs with similar spacing of teeth. Patients who consistently used the end of the comb with narrower teeth may have collected more hairs. Finally, it is difficult to extrapolate from these 60-second results what the total hair loss per day is. It is difficult to know whether vigorous combing would eliminate hairs that might have been lost later that day, or two days later.

A Peroxide Paradox

Citation

Wasserbauer, S., D. Perez-Meza, and R. Chao. Hydrogen peroxide and wound healing: a theoretical and practical review for hair transplant surgeons. *Dermatol Surg* 2008; 34:745–750.

An important controversy in both the dermatology and hair transplantation communities is the question of whether hydrogen peroxide (H_2O_2) enhances or inhibits wound healing. Hydrogen peroxide is helpful in hair transplantation for its effervescent effects of dissolving clotted blood and mechanically removing tissue debris both at the donor and recipient sites. It is frequently used as a 1–3% solution, diluted in various ways such a 1 part saline, 1 part H_2O_2 to 3 or 4 parts saline with 1 part H_2O_2. In this paper, Wasserbauer, et al. performed a literature search to investigate the *in vivo* and *in vitro* effects of hydrogen peroxide.

The authors found four studies demonstrating the beneficial effects to include stimulation of vascular endothelial growth factor (VEGF) release from macrophages, activation and mediation of transforming growth factor (TGF-β1), and induction of fibroblast proliferation/collagen formation. These mostly *in vitro* studies suggest that hydrogen peroxide may enhance wound repair and revascularization of the hair graft after transplant surgery. Four other studies, also mostly *in vitro,* found numerous adverse effects of H_2O_2 on wound healing. These found cytotoxic effects on fibroblast cultures, inhibition of human keratinocyte migration, and induction of apoptosis of epithelial cells. These studies suggest that when hydrogen peroxide is converted by neutrophils to more reactive oxygen species (ROS), such as superoxide and hydroxyl radicals, it may adversely affect wound healing.

Only two *in vivo* studies have been performed investigating the effects of H_2O_2 on graft viability during hair transplantation. Both were small studies that involved immersing the grafts directly in hydrogen peroxide at increasing concentrations. Although the numbers were few, they found that using solutions of 1–1.5% H_2O_2 caused no problems, but that decreased growth rates were found using the 3% concentration of hydrogen peroxide.

Comment

It is clear that the hair transplant community needs to perform more *in vivo* studies with higher power to investigate the effects of hydrogen peroxide on graft viability. This review, while thorough, only serves to underscore the lack of clear evidence supporting the use of hydrogen peroxide in hair transplantation or other settings that require wound healing, such as dermatologic surgery.✧

Letters to the Editors

Gaetano Agostinacchio, MD *Porto Recanati, Italy*

Re: Response to Michael L. Beehner's "Focal dense-packing in hair transplantation"

Our colleague Dr. Michael Beehner explains in his article (*Forum* January/February 2008; 18(1):5-13) how to surgically treat the problem of thinning behind the front hairline both in male and female patients. However, in my opinion, it is not always right to intervene surgically when a precise diagnosis has not been made and when we are unaware of how the problem will develop.

An accurate diagnosis at the beginning is vital in determining the medical or surgical therapy to be adopted.

Considering that the mechanism responsible for hair loss in these patients is not an excess of androgen but an estrone deficiency, a hair transplantation may not solve the problem, and in fact the transplanted hair may fall out due to a lack of estrone. Therefore, I consider these patients not candidates for hair transplantation.

In my experience, both male and female patients with hair thinning problems similar to those published in Beehner's article (which are classified as Ludwig female pattern hair loss), benefit from a topical therapy that consists of a cocktail of medicines that include hydrocortisone, progesterone and estrone as active ingredients dissolved in ethyl alcohol to 75 degrees (the author refuses to reveal the exact percentage of the composition since he has this lotion under patent pending) (see Figures 1 and 2).

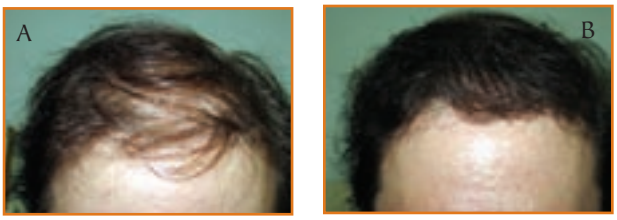


Figure 1. A: 54-year-old female patient;
B: same patient after 1 year of topical treatment

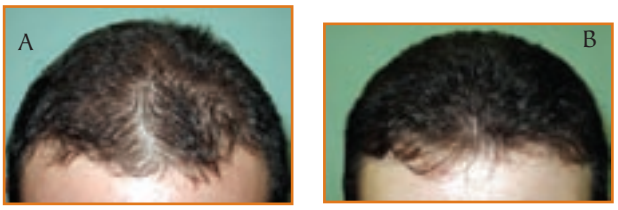


Figure 2. A: 35-year-old male patient;
B: same patient after 1 year of topical treatment

IN REPLY

Mike Beehner, MD *Saratoga Springs, New York*

Re: Reply to Dr. Agostinacchio

I think Dr. Agostinaccio missed the intent of my concept of "focal dense packing." It was not meant in any way to shortcut the process of being certain of the presenting diagnosis of alopecia in the patient before you. For the most part, my use of this modality has been almost exclusively in hereditary androgenetic alopecia in males and hereditary female pattern hair loss in females. I keep as wary an eye as anyone looking for diagnostic or physical exam clues that the diagnosis may be something else, and am quick to biopsy if that thought even occurs. My article was mainly about marking out a relatively small key area within the overall transplant pattern, most commonly in the "frontal core" area, and simply placing as many hairs in that small area as you humanly can. In my hands, the method that works best is to use the stick-and-place method with 2-hair FUs placed into 21, 20, or 19g needle sites, usually in a density of around 50 FU/cm^2 or 100 hairs/cm^2. I am still dealing with the rest of the larger transplant pattern also, but just not in as dense a fashion as this special area. It's simply a way to "jump-start" a key, visible area and perhaps get two sessions' worth of density in that spot, while planting the remaining area in the usual manner, which respects the blood supply of the scalp.

To the contrary, when I see small, isolated areas of alopecia, that is often an unlikely area for this technique, as many of them turn out to be burned out scarring alopecias, in which I want to temper my planting density to allow for adequate vascular support to the grafts planted. Barring an obvious diagnosis, such as hairpiece clip bald spots or trauma, I agree with Dr. Agostinacchio that all such areas should be biopsied.

As to his comments on the hormonal cause of female hair loss, I am quite certain it is in fact different from the male hormonal situation, but am not aware that the answer is as worked out and simplistic as he implies. I am certainly impressed with the photos and the results he shows, and would be interested to see this therapy performed on a number of female patients who all responded similarly. If such was true, this would be a major breakthrough. Barring such evidence forthcoming, I would have to remain skeptical of his basic premise.

⇨ *More Letters to the Editors on page 195*

The commoditization of surgical hair restoration—a cautionary statement

Jeffrey Epstein, MD *Miami, Florida*

The other day, I was contacted by a patient, a law student low on cash, who asked if I could match a quoted fee of $3,000 for a 1,300 follicular unit transplant procedure provided by a reputable New York City surgeon—to be performed in the peak of the summer season. After informing this patient that I would not be able to come even close to this price, I then asked myself, how could that surgeon make any amount of reasonable money on this case? And this leads me to the more important concern, What is happening to our wonderful specialty?

To anyone involved in this field, it is known that, overall, hair transplants have continually gone down in price. Perhaps when surgeons were charging $8 to $10 a graft, there was an indication for fee reduction, but now, fees are consistently going to $3 and less per graft by some of our colleagues. This trend is concerning, for there is essentially no end to how low it can go.

In the widely accepted "guerrilla marketing" approach, in order to successfully compete against others in the marketplace, it is recommended that any business, or for that matter, any physician, should pick one attribute or feature with which one can stand out. For example, FedEx—guaranteeing the package arrives the next day ("when it absolutely, positively has to be there the next day"). In the automobile industry: Cadillac—the smoothest ride; BMW—top German engineering; Ferrari—prestigious Italian passion; and Volvo—the safest. All of these attributes, in all very successful companies, promise some type of value, and for a competitor to surpass them, they have to further "up the ante" on that value. While quality can continue to slowly rise, there is some limiting ceiling as to how "high" that value can go.

Not so with price, however. Once companies, or for that matter, hair transplant surgeons, choose to compete on price, there is no limit to how low that price can go. There is always someone who can charge less, and once one chooses to play that game, the only way to compete is to further lower fees. This practice is so destructive to any industry, for at some point, providers have no choice but to start cutting corners, leading to poorer and poorer quality results. I know: Some of you are saying to yourselves or each other "Boy, that Epstein, doesn't he know that it is in fact possible to combine top quality with low fees—I do it every day." But the reality is, at some point in the future, by competing with lower and lower fees, eventually there will be many losers—including the "winners" of the lowest fee competition.

Essentially, by these efforts to attract patients with lower and lower fees, what I believe is happening is the commoditization of hair transplantation. Similar to how Kmart, Target, and the "winner" in the price wars, Wal-Mart, led customers to believe that the only thing that matters is getting the very lowest price, more and more of our prospective patients are developing the mind-set that a hair transplant is just a hair transplant, and the goal is to seek out the lowest price per graft. We, as a specialty in general, are fostering this mentality, and should attempt to learn a lesson from such industries and businesses as department stores, automobiles, and our physician colleagues competing for HMO contracts. To stay the price leader, as there is always someone willing to lower their profit margins, prices can only get lower and lower.

Hair transplantation is an art. It is a cosmetic surgical procedure, with risks, as well as tremendous variability in outcomes largely dependent upon technical and aesthetic skills. I call on my colleagues to not participate in the commoditization of our specialty, and rather regard your work with pride and respect.✧

Jim Vogel, MD *Owings Mills, Maryland*
Re: It's a small world—of friendship

One of the most special aspects to the ISHRS is the international friendships we develop over the years and even the friendships our children make with other members' kids in our Society as well. We should keep this in mind and never forget that the foundation of our Society is friendship and sharing of information. Never are these tenants of our cherished Society more realized than when we travel beyond our own boundaries and we are welcomed by our colleagues in a different country.

We just returned from a terrific few weeks in Eastern Europe. We visited with the Karl and Claudia Moser in Vienna who were incredible hosts and also got to know a newer member of the Society, Tomas Mantse, in Budapest.✧

Dr. Vogel spending an educational morning with Dr. Hugeneck (left) and Karl Moser (right) at the Moser Clinic in Vienna.


Tomas Mantse (an IHRS member from Budapest) and Jim Vogel


At dinner with the Vogel family with Karl and Claudia Moser

Cyberspace Chat

Sharon A. Keene, MD *Tucson, Arizona*

Rogaine foam in women: Precautions for use

The following discussion took place in regard to a woman patient inquiry about the use of Rogaine to treat her hair thinning.

Bob Leonard reported this conversation: "I had a woman come into the office today who was concerned about using Rogaine foam. It has been my practice to recommend this product to men and women alike since it became available early last year. I think it is far easier and much less messy for patients to use than the liquid formulations. She indicated that she read on a medical website that Rogaine Foam can cause cardiac problems in women. Anybody hear anything about this issue?"

Bill Parsley responded: Apparently topical minoxidil causes cardiac arrhythmias in about 1/1,000 patients. I have been using 5% on both women and men and have not seen a problem in women yet. It was my impression that the main worry was a higher incidence of facial hypertrichosis.

Bill Rassman added: Don't forget that minoxidil was originally used for the treatment of hypertension and can reduce the blood pressure if absorption is high enough. I have seen patients complain of lightheadedness with the drug, which I always believed was caused by systemic absorption.

Shelly Kabaker also recalled: I had a physician patient 13 years ago who had a pharmacist compound minoxidil and increasing the concentration in hopes of a greater effect. At 15% concentration he had a hypotensive episode while driving and wrecked his car (fortunately no physical injuries occurred). He subsequently had a transplant.

Editorial Review

In brief review of this commonly used, over-the-counter medication, minoxidil is a potassium channel agonist. It contains the chemical structure of nitric oxide (NO), a blood vessel dilator, and may be a nitric oxide agonist. This appears to explain its activity as a vasodilator but may also be related to its mechanism of hair growth, too. The following information was available from medscape.com regarding systemic absorption and side effects. One that isn't mentioned is facial hair in some women (reported incidence 3–5%)! Percutaneous absorption of minoxidil after application of 1 or 5% minoxidil solutions to the scalp generally averaged 1.6–3.9% of the applied dose, based on urinary recovery of radiolabeled drug. Increasing serum concentrations were observed in cases of scalp irritation. Following cessation of topical minoxidil dosing, approximately 95% of systemically absorbed drug is eliminated within 4 days. A list of infrequent, and then rare, side effects is provided.

Less frequent: Dermatitis due to topical drug, Dry skin, Erythema, Pruritus of skin, Skin rash, Urticaria

Rare: Alopecia, Angioedema, Body fluid retention, Chest pain, Conduction disorder of the heart, Decreased sexual function, Dizziness, Eczema, Edema, Folliculitis, Headache disorder, Head sensation disturbance, Hypotension, Neuralgia, Reduced visual acuity, Tachyarrhythmia, Vasodilation of blood vessels, Visual changes

Notwithstanding this information, however, the results of a multi-center, randomized, placebo-controlled trial are reported here. A total of 381 women (18–49 years old) with female pattern hair loss applied 5% topical minoxidil solution (n = 153), 2% topical minoxidil solution (n = 154), or placebo (vehicle for 5% solution; n = 74) twice daily. At week 48, the 5% topical minoxidil group demonstrated statistical superiority over the 2% topical minoxidil group in non-vellus hair counts as well as investigator and patient assessment of treatment benefit. Both concentrations of topical minoxidil were well tolerated by the women in this trial without evidence of systemic adverse effects.[1]

It is important to remember that minoxidil, while very helpful and safe in most cases, is still a drug. Currently it remains a mainstay of therapy for women, who still have few medical options for achieving hair regrowth.

Reference

1. Lucky, A.W., et al. A randomized, placebo-controlled trial of 5% and 2% topical minoxidil solutions in the treatment of female pattern hair loss. *J Am Acad Dermatol* 2004; 50:541-53.✧

Surgical Assistants Co-editors' Messages

Betsy S. Shea, LPN *Saratoga Springs, New York*

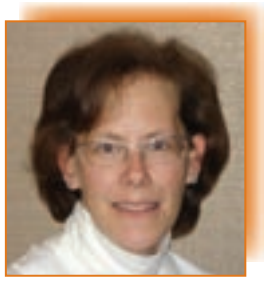
Dear Assistants,

Recently, I read an article in a paper about the benefits of teamwork, written by best-selling author Harvey Mackay. The article spoke about how there is strength in numbers. Working as a team will not only accomplish more, but will also improve the quality of what's being done. Mr. Mackay made reference to the great redwood trees of California. How despite the fact that some of them are over 300 feet tall and thousands of years old, their root systems are very shallow; but the reason they have survived for so long despite is because they exist together and their root systems intertwine. They work together: holding each other up and protecting each other when the storms come through. We can learn a lesson from these trees:

Stand together, proud and tall. • Work as a team.
Intertwine your roots. • Protect each other from the storms.
Work hard as a team and much can be accomplished.

Betsy

Laurie Gorham, RN *Boston, Massachusetts*



Bonjour Assistants!

The year has flown by and I can't believe it's time for us to meet again. I'm looking forward to our meeting, sharing ideas and catching up with everyone. It's so important for our group to be able to impart wisdom and guidance to new comers to our field so they can grow and develop as we have over the years. Safe travels everyone!

J'attends avec impatience voir tout le monde dans Montréal.

Warmest regards,

Laurie

Patient welfare

Marina Rovdo, Hair Restoration Ltd. *Dublin, Ireland*

Upon arriving for surgery, a patient is often both excited and worried. This is why, in our clinic, we have a dedicated staff member who is responsible for our patient's welfare each day. Let me share my experiences, as I do this most often.

My main objective is to create a relaxing and comfortable feeling for the patient. This involves:

- Reducing pre-operative stress
- Establishing a friendly and professional relationship with the client
- Creating a positive image of the clinic and trust in what we are doing
- Creating a relaxed environment for the patient through small creature comforts, such as preparing tea/coffee, breakfast and lunch, etc.

I read the patient's notes in advance and meet the patient on arrival. As I bring him to the surgery rooms, I like to chat and try to assess his anxiety level by observing his gestures and listening to his voice. This helps me gauge the tone and manner I should use with him. For example, with nervous patients, I speak more slowly and gently.

I stay with the patient during the preparation stage to ensure he will recognise me easily during the day. It's important that he has a familiar face among the staff, as various people will be around him during the day.

I attach the ECG leads to the patient and explain the details of the procedure, including:

- The importance of being still, and that if he wants to move to tell us first.
- When breaks are scheduled and that he can ask for breaks, drinks, etc.
- What to expect during the next stages including design and donor strip removal.

When speaking with a patient, avoid words like "needle" or "blood," which might distress the patient.

After the donor strip removal, I bring the patient from the operating table to the patient's room. I ask how he is feeling and if he needs anything. Sometimes patients need a little more time to talk just to ensure they feel understood.

In the surgery, the patient should never be left alone. In contrast, at break time, most patients prefer some time to themselves. I check every five minutes that the patient is content. In our clinic, we have a large DVD library, so I offer each patient his choice of movies and what he would like to eat for lunch.

After the break, I bring the patient back to the operating table, reattach the ECG leads, and switch on the monitor. I will then tidy the patient's room. During the surgery it's important to observe the patient and from time to time to ask if he needs water or a short break. Simply being there is very important as it reassures the patient.

The best indicator that I have done a good job is when the patient calls me by my name and refers to me when he needs something. Empathy, courtesy, and patience make for good patient welfare—and never underestimate the importance of a smile!✧

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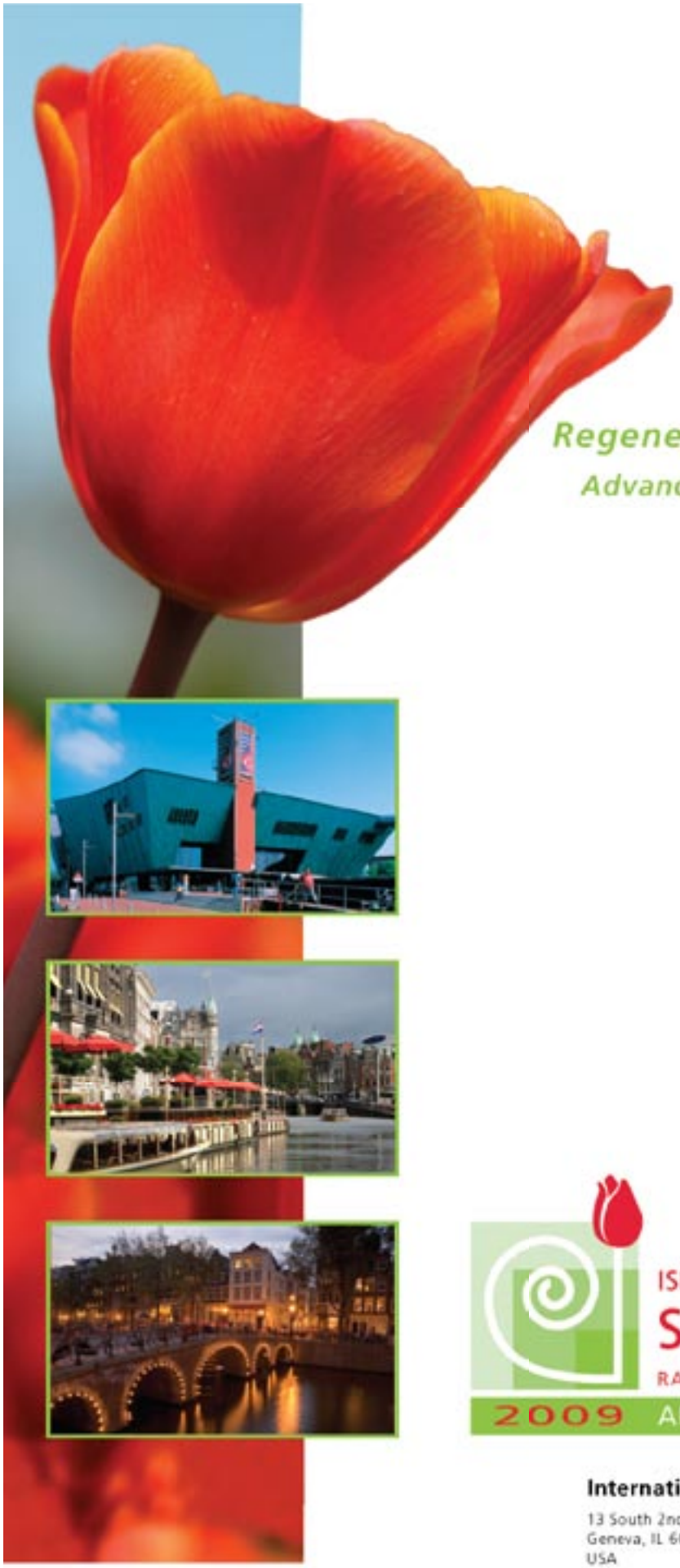

Save the Date

Cultivating the Regenerative Beauty of Nature: Advances in the Science and Surgery of Hair Restoration

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The Call for Abstracts will go out in October.
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Advancing the art and science of hair restoration

Upcoming Events

Date(s)	Event/Venue	Sponsoring Organization(s)	Contact Information
Academic Year 2007–2008	Diploma of Scalp Pathology & Surgery U.F.R de Stomatologie et de Chirurgie Maxillo-faciale; *Paris, France*	Coordinators: P. Bouhanna, MD, and M. Divaris, MD Director: Pr. J. Ch. Bertrand	Tel: 33 + (0)1 + 42 16 12 83 Fax: 33 + (0) 1 45 86 20 44 *marie-elise.neker@upmc.fr*
October 16–18, 2008	III Congress of Brazilian Association of Hair Restoration Surgery Pestana Rio Atlantica Hotel, Copacabana Beach *Rio de Janeiro, Brazil*	Brazilian Association of Hair Restoration Surgery (ASSOCIAÇAO BRASILEIRA DE CIRURGIA DA RESTAURAÇAO CAPILAR - A.B.C.R.C.)	President: Marcelo Gandelman, MD Chairman: Henrique N. Radwanski, MD *Dr.Henrique@pilos.com.br*
November 8, 2008 10:00AM–1:00PM Central Time	Advanced Webinar: Advanced Hair Transplant Principles and Planning *(online seminar)*	International Society of Hair Restoration Surgery *www.ishrs.org*	Tel: 630-262-5399; Fax: 630-262-1520 *www.registration123.com/ishrs/07WEBINARS/*
November 15–16, 2008	14th Annual Scientific Meeting & Video Surgery Workshop JAL Resort Sea Hawk Hotel Fukuoka	Japan Society of Clinical Hair Restoration www.jschr.org/	President: Masahisa Nagai, MD Tel: 81 + 92-483-7575 Fax: 81 + 92-483-7580 *kamitomo@nagai-clinic.jp*
January 24, 2009 10:00AM–1:00PM Central Time	Advanced Webinar: Quality Assurance and "Six Sigma" Strategies in Hair Transplantation *(online seminar)*	International Society of Hair Restoration Surgery *www.ishrs.org*	Tel: 630-262-5399; Fax: 630-262-1520 *www.registration123.com/ishrs/07WEBINARS/*

Make note!

Dates and locations for future ISHRS Annual Scientific Meetings (ASMs)

2009: 17th ASM, July 22–26, 2009, Amsterdam, The Netherlands

2010: 18th ASM, October 20–24, 2010, Boston, Massachusetts, USA

2011: 19th ASM, dates to be determined, Anchorage, Alaska, USA

2012: 20th ASM, October 17–21, 2012, Paradise Island, Bahamas

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