Review of the
Literature: Dermatology

Marc Avram, MD *New York, New York;* Nicole Rogers, MD *New Orleans, Louisiana*

Traction Trouble?

Citation

Khumalo, N.P., et al. Determinants of marginal traction alopecia in African girls and women. *J Am Acad Dermatol.* 2008; 59:432-438.

Many African American women apply relaxers (sodium hydroxide and guanidine hydroxide) for 5-7 minutes to create slightly loose curls, or for 10-20 minutes to create long, straight hair. However, such products can cause severe damage to the hair shaft, resulting in hair loss. A South African study of over 1,000 women and girls sought to identify the major factors leading to marginal traction alopecia hair loss along the frontal hairline and temporal scalp. Factors investigated were the use of relaxers (frequency and time left in hair), hair dye, use of braids, presence of symptoms, and use of salon conditioning. They found that the odds ratio for traction alopecia was higher in adults than children, probably reflecting a longer history of hair styling practices. They also found that traction alopecia was higher with braiding-related symptoms than with chemical-related symptoms. The highest risk was when traction, through braiding or glued extensions, was added to relaxed hair.

Comment

Many patients presenting with hair loss are affected by traction alopecia. It is important to recognize this condition and acknowledge the emotional effects it can have. It is also important to educate our patients about the potential effects of chemical relaxers and perms. Early stages of traction alopecia may be regrown using intralesional injections of anti-inflammatory medications or even topical minoxidil. However, long-standing traction alopecia may require surgical intervention through hair transplantation.

Surprise Scarring!

Citation

Donovan, J.C., D.M. Ghazarian, and J.C. Shaw. Scarring alopecia associated with the use of the epidermal growth factor receptor inhibitor gefitinib. *Arch Dermatol.* 2008; 144:1524-1525.

Epidermal growth factor inhibitors such as gefitinib (Iressa®) and erlotinib (Tarceva®) are chemotherapeutic medications that have been used to treat non-small cell lung cancer. Previously, they have been reported to cause follicular eruptions on the skin. Recently, there was a report of scarring alopecia in a 70-year-old woman with stage IV non-small cell lung cancer. She developed erythematous scaling and crust about 8 months after starting gefitinib, which progressed to hair loss over the next two years. Biopsy confirmed chronic inflammation and fibrosis that obscured the upper portion of the hair follicles. When her condition was finally diagnosed, the drug was discontinued. It was difficult to know whether her condition would have resolved because she died 2 weeks later of widespread metastatic disease.

Comment

Although these patients will likely not present for hair transplantation, given other more severe comorbidities, it is a side effect worth recognizing.

Ant-eating Alopecia?

Citation

Namazi, M.R., and J.L. Jorizzo. Ant-induced alopecia: A case report and literature review. *Arch Dermatol.* 2008; 144:1526-1527.

A case report from Iran describes a 35-year-old man who presented to a dermatology clinic with a 3 × 3.5cm area of hair loss that had occurred overnight and clinically matched the appearance of alopecia areata. He also reported some mild pruritus and a number of ants in his bed. On clinical exam it appeared that the hair had been trimmed 1-2mm above the scalp. Several tiny erythematous macules suggested sting points. Evaluation of the ants collected from his bed found them to be of the genus Pheidole. Since 1999, two other case reports of 16 and 4 patients, respectively, suffered hair loss from such ants feeding on their hair. These ants are believed to be lipophilic and may be attracted to greasy scalps. Why they cut the hair is not clear. They may be used for nutrition, nest building, or other purposes.

Comment

So far, all such reports have been from Iran or Turkey. We include this for our international hair transplant surgeons who may come across this unusual cause of hair loss. Such patients would not require hair transplantation, but rather time to regrow their hair (and a good exterminator!).✧

Surgeon of the Month: Sam Lam, MD

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

Dr. Sam Lam, MD, and his staff
Plano, Texas

Dr. Sam Lam was born in Hong Kong and came over to Texas at the tender age of 3, where he was raised. He was greatly influenced during his childhood to enter the medical profession by his father who was a family physician in Dallas and with whom he had the joy to practice medicine in the same office for several years. Sam has a sister, Vina, who is a web designer and who resides in New York with her husband Matt. His lovely mother, Carol, is his office manager and developer of his 27,000 square foot building, which combines his vision for wellness and aesthetic care. Sam is also the owner of a salon and spa in his building.

Sam graduated Cistercian Preparatory School just outside of Dallas as Valedictorian and went to Princeton University for his undergraduate studies, majoring in modern European history with honors. He then went to Baylor College of Medicine attaining the Bobby R. Alford Award, followed by a residency in head and neck surgery at Columbia University. He finished his facial plastic surgery fellowship with Dr. Edwin Williams in upstate New York where he also trained in hair restoration. From that experience, he wrote his first textbook, Comprehensive Facial Rejuvenation, which featured Dr. Williams' technique in hair transplantation.

In addition, Sam has written 4 other books: Cosmetic Surgery of the Asian Face (2nd Edition), Complementary Fat Grafting, Simplified Facial Rejuvenation, and his forthcoming book, Aging Face: The New Paradigm, which features Emina Karamanovski, his hair-transplant coordinator, and his technique on hair restoration. Sam credits Emina for maturing his education in hair restoration and for being a great partner in the field. Sam's practice is limited to facial cosmetic surgery and hair restoration, where hair transplant surgery consumes about half of his busy practice. He is proud to be a Diplomate of the ABHRS.

Sam's practice in hair restoration is varied and diverse, attracting a broad spectrum of ethnicities as well as a large percentage of women. He uses both mixed grafts as well as pure follicular unit grafting depending on the clinical situation. Sam is known worldwide for his fat grafting technique for facial rejuvenation and has lectured on how he understands fat transplants in the context of how hair grafts evolve over time. More specifically, he sees that at 3 to 4 months fat transfers become quiescent when the swelling is gone but the result is not apparent until the graft starts to grow and shape, from 6 months up until about 18 months, a very similar trajectory to how a hair graft grows.

Sam's interests include creating and admiring art. He undertook most of the paintings for his wellness building, completed all the illustrations for his textbooks, and even designed all the logos for his practice and those of his tenants in his building. He is a movie aficionado, enjoys listening to business audiobooks, and is a certified PADI divemaster, having dived across most parts of the globe. Sam has a real passion for hair transplant surgery and relishes sitting back and admiring the recipient sites he has created.✧

2009 Dues Reminder

If you have not yet remitted your 2009 dues renewal, please do so today!

Go to our secure website at www.registration123.com/ishrs/DUES/ and enter a valid credit card (American Express, Discover, MasterCard or Visa).

If you have any questions, please contact Liz Rice-Conboy, Membership Manager, directly at (630) 262-5399 or toll free in the U.S. at (800) 444-2737.

Pearls of Wisdom

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

I extend my personal greetings to you from New England just after a wonderful meeting (except for the room service!) in Montréal. Congratulations to Dr. Arthur Tykocinski and our administrative staff for their tremendous effort to make it such a success.

Plans spearheaded by our new President, Dr. William Parsley, and our Executive Director, Victoria Ceh, are already under way for our next meeting in Amsterdam. This will be a meeting not to miss! Make your travel plans now. I invite particularly all of our European members to make an extra effort to attend—and, bring along a few colleagues as well to participate in this meeting close to home.

See you in Amsterdam!

QUESTIONS: • How many days do you keep your donor area sutures (staples) in place? • Do you keep them in for a longer (or shorter) duration in certain circumstances? When would you use a double-layered closure (if ever)? • Which suture material do you use?

Dr. Antonio Pistorale from *Bologna, Italy,* provides:

I usually keep my donor area staples in place for 13 to 16 days. I never remove them before 12 days, neither in first sessions nor in very loose scalps. In particular circumstances, such as very tight scalps or some secondary sessions, I prefer staples stay in place for 5 to 7 more days.

In the past, I used staples in craniofacial surgery both in infants and in adult patients and I realized that final scar appearance is not influenced by a longer duration of staples in place. If left in for a shorter time, even with no skin excision and no tension, sometimes wider scars develop. I've been using double-layered closure for some years, only during my "nylon age," since then I started my "staple age," which is still alive and well. Now I never use double-layered closure, I prefer, in particular cases, a wide undermining of the edges but I still just use a single staple layer. Since then, I have never noticed any subcutaneous inflammation, which is sometimes caused by deep suture resorption; scar maturation also appears to occur faster.

I started using staples after considering better scars in craniofacial surgery and face lift procedures. In fact, many eminent plastic surgeons, and myself, choose staples for suturing where the scar enters the scalp in face lift procedures. I think that well positioned staples make a more stable positioning of the flaps, with the same strength until their removal, while sutures' strength and stability lowers in the same number of days; this could be detrimental in some donor scar cosmetic healing.

The only disadvantage of staples is postoperative discomfort during sleeping, but I found a simple trick: a common U-shaped travel pillow can be effective to avoid pressure on the scar and patients tell me they can sleep well with no pain.

Dr. Troy Creamean from *Corpus Christi, Texas,* indicates:

I use a 2-0 running Prolene and leave it in for 10 days. I suture above the hair follicle to prevent pressure necrosis and thus hair loss at the donor site. I rarely undermine tissue unless I've harvested greater than 1.5cm wide.

Dr. Wanda Bloisi from *Cadoneghe-Padova, Italy,* indicates:

I hardly ever use staples. I use Prolene 3-0 and leave it on for about 12 to 15 days, depending on the patient's engagements or with slower healing. I usually avoid having too much tension by excising narrower strips, and, therefore, double-layered closure is not required, though sometimes I feel safer to use it.

Dr. Mark Di Stefano from *Worcester, Massachusetts,* states:

For conventional closures I was using 7-8 days for suture removal. I closed with 3-0 Vicryl interrupted sub Q and 2-0 Prolene running suture for skin.

Now most of my closures are trichophytic in nature. I do not use a sub q suture and I use 4.0 nylon running suture for skin. I keep them in for 12 days.

Dr. Dominic Brandy from *Pittsburgh, Pennsylvania,* offers:

I am currently using an interrupted 0-Monocryl for deep closure. For the skin, I typically will use a running 4-0 Chromic suture and let it dissolve and find that most of my patients appreciate the convenience aspect of the dissolvable suture.

Dr. Marla Rosenberg from *Toronto, Ontario, Canada,* states:

Donor area sutures (I don't use staples) are normally kept in for 7-8 days. If there is old scar tissue present or tension on the wound, then sutures are removed at 10 days. I use 2-0 or 3-0 nylon suture, usually 2-0.

Dr. Robert Reese from *Edina, Minnesota,* provides:

Routinely I leave the occipito-parietal suture in place for 10 to 12 days post transplant. I may leave the suture in place for an additional two days if there is any tension on the wound edges; for example, as may occur in a patient who is undergoing a second transplant procedure, or one who has little natural scalp laxity on an initial procedure.

With transplant procedures getting larger, I routinely perform "two layer" closures. I use 2-0 or 3-0 Vicryl for the deep layer to re-approximate the wound, leaving little tension on the skin edges. I believe that this helps to minimize mechanical creep, which can lead to a wider incision. I then re-approximate the skin edges with a simple running 3-0 nylon suture.

Generally speaking, I do not feel that a trichophytic closure is required for the patient who has narrow color contrast between the color of his or her hair and scalp. These incision lines naturally blend and are of little if any consequence for the patient even if they wear their hair very short. For the patient who has wide color contrast (e.g., dark brown hair with Caucasian scalp) between hair and scalp, I usually perform a trichophytic closure, beveling the inferior wound edge.

Dr. Rajendrasingh Rajput from *Mumbai, India,* relays:

I keep sutures for 10 days using a single-layer absorbable closure with a 3-0 Vicryl suture.

I always use undyed Vicryl suture as the violet dye often gives skin reaction.

Single-layer closure takes a full thickness bite from sub dermal fat tissue to the dermo-epidermal junction passing parallel to the follicles and not across the follicles, which can strangle the roots leading to unacceptable hairless scars.

The scars are 2-3mm thin, no hypertrophy, and have hair growth along the scar.

Suturing is not ended with a knot but by passing the suture criss-cross through the sub dermal layers coming out of the skin and re-entering back through the same skin hole.

Dr. Luis Ortega from *Guayaquil, Ecuador,* indicates:

I don't let the sutures stay in longer than 12 days. Sometimes, if the patient asks me about taking the sutures out sooner, I leave them in place no fewer than 8 days, but almost never less than 10 days. I do only a running suture using 3-0 Monocryl, only in one layer.

Dr. Damkerng Pathomvanich from *Bangkok, Thailand,* states:

I have used staples in the past and have removed them in one week. Now I'm using Rapide Vicryl and the patients do not need to come back for suture removal. I use single layer with retention stitches for strips wider than 1cm and on subsequent sessions.

Dr. Piero Tesauro from *Milan, Italy,* shares:

I think that each device has a learning curve, even the staples, which I consider quite easy to use, but, like many others, I tend to use what I have from my supplier and I forget that even small experiments can add knowledge to our practice. For this reason I think that other questions can be added to yours, such as: How many days do you keep your donor area sutures (staples) in place?

Usually I leave staples in place for 10-12 days whenever possible. I prefer to remove staples in two sessions. I remove the first half after 9 days and the second half after 12 days. If the patient is coming from abroad, I provide a staple remover and I teach someone in the family to remove the staples.

In secondary cases, I remove staples after 15 days. I routinely use 3-0 or 4-0 Vicryl in young patients, in cases with tension, and in all cases when the patients will return quickly to sports activities. The use of staples is widely accepted, but I think that it is necessary to investigate the differences among brands.

Other questions to ask include the following: Do different brands produce different results? Should we use deep staples or wide staples in cases of tension or in cases of deep scalps? Do certain designs tend to cut the skin more than others? Should we consider as important the wire diameter like we usually do when we choose a normal suture? Even more, should we consider as important the shape of the wire—preferring a flat shape more than a round shape?

Every brand provides different sizes, for example:

Royal

- In the closed position, the regular staple has a width/crown of 4.8mm and leg length of 3.4mm; the wide staple has a width/crown of 6.5mm and leg length of 4.1mm.

Appose

- Two staple sizes—4.8mm (Reg.) and 6.5mm (Wide)—provide maximum wound closure flexibility.
- Two staple heights: 3.4mm (Reg.) and 4.1mm (Wide)

Autosuture MULTIFIRE PREMIUM

- Each stapler contains stainless steel staples of 0.51 mm diameter wire. The staple span is 10.2mm before closure and approximately 4.8mm wide and 3.4mm high when closed.

3M PRECISE

- Wire Dia: 0.51-0.53mm (Regular), 0.55-0.58mm (Wide)
  Width: 5.0-5.7mm (Regular), 6.4-7.1mm (Wide)
  Depth: 3.5-3.9mm (Regular), 3.9-4.7mm (Wide)
  Autosuture SFS (reusable skin stapler)
- Regular: 0.51mm diameter wire; staple span is 10.2mm before closure and approximately 4.8mm wide and 3.4mm high when closed.
- Wide: 0.56mm diameter wire; staple span is 14.1mm before closure and approximately 6.5mm wide and 4.7mm high when closed.

Ethicon, Inc PROXIMATE PLUS

- Regular staples have a diameter of 0.53mm, a span of 5.7mm, and a leg length of 3.9mm.
- Wide staples have a diameter of 0.58mm, a span of 6.9mm, and a leg length of 3.9mm.

Dr. Robert Bernstein from *New York, New York,* provides:

I use double-layered closure in 100% of the cases, deep with 4-0 Vicryl, and I use Monocryl—that I don't remove— in 70% of the cases. In the other 30%, I use 4-0 Nylon when there is poor elasticity, a second or third procedure, or a history of Monocryl reaction

Dr. Antonio Ruston from *Sao Paulo, Brazil,* states:

I remove half my sutures at 10 days; the remainder at 20. I rarely keep them in longer, only with very tight scalps. I rarely use a double-layer suture. I use 2-0 Vicryl.✧

Letters to the Editors

Robert J. Reese, DO *Edina, Minnesota*

Re: Become a Diplomate of the ABHRS

Recently I had the opportunity to attend the Annual American College of Phlebology (ACP) meeting in Marco Island, Florida. Like the Annual International Society of Hair Restoration Surgery (ISHRS) Meeting, it provided an opportunity to learn, share ideas, network, and enjoy the company of many talented professionals.

At the ACP meeting I was honored with achieving Diplomate status by passing the inaugural American Board of Phlebology (ABPh) examination, and I am proud to have placed this certificate in my office. The ACP and the ISHRS have been recognized by the American Medical Association and the American Osteopathic Association as recognized subspecialty fields of study. But both the ABP and the American Board of Hair Restoration Surgery (ABHRS) certificates have not yet achieved American Board of Medical Specialty (ABMS) accreditation.

While attending the ISHRS meeting in Montréal I had the opportunity to talk with many qualified hair transplant surgeons who have not yet achieved Diplomate status by the ABHRS. My question to them was, "Why have you not taken the exam?" The most common responses centered on "It's not an ABMS accredited exam." and "I'm considering taking the exam but it would take a substantial commitment of my time."

The ABPh believes that with time, and an increasing number of Diplomates, they may eventually achieve accreditation by the ABMS.

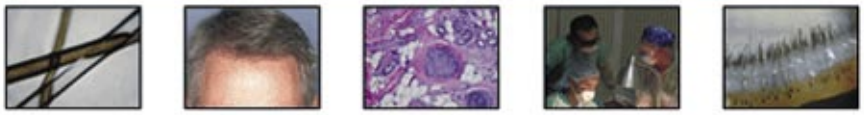
Currently, the ABHRS has less than 140 Diplomates, and the exam has been offered for a decade or longer. It is my strong opinion that if we can increase our number of Diplomates, we will increase our influence towards gaining ABMS status.

Having taken and passed each of these examinations, I can tell you unequivocally that the far superior exam is provided by the ABHRS. I can tell you that you will consider yourself a much better hair restoration surgeon for preparing for, and passing, the ABHRS exam. I can state that you will be VERY proud of your accomplishment. And you will proudly hang your diploma in your office. You will also feel the pride of knowing that you have attained the most comprehensive knowledge base for providing the very best care for your patients. And you will feel a great deal of satisfaction in knowing that you are supporting your profession.

Where would each of us be without the field of hair restoration surgery? Since attending my first ISHRS meeting in 1999 in San Francisco, I was sold on the camaraderie and esprit de corp of the profession. Right then and there I decided to become the very best hair restoration surgeon that I could possibly become. Becoming a Diplomate of the ABHRS was one step in achieving this goal. I am humbled by having the honor of being selected as a member of the Board of Directors of the ABHRS and chairing the written exam. The sky is the limit if you choose to participate.

There is strength in numbers. If the ABPh has the lofty goal of achieving ABMS accreditation, then there is no reason why the ABHRS cannot do the same. With your participation, our profession can strive towards this lofty goal as well. Therefore, I would like to request your serious consideration to take your credentials to the "next level" by committing to take the ABHRS examination within the next two years.✧

2007-2008 Advanced Webinars



Don't miss this advanced learning opportunity!

The ISHRS Advanced Webinars are devoted to topics identified by physician members and/or the ISHRS Core Curriculum in Hair Restoration Surgery as necessary to professional enhancement or patient care, and are taught at an **advanced level.** Each Webinar is led by a recognized leader in the field of hair transplantation and when appropriate has adjunct faculty that are renowned for their work in a particular area. Each Webinar offers up to 3 hours of *AMA PRA Category 1 Credit™*. Go to the Advanced Webinars website for further information, technical requirements for participation, and to register.

James A. Harris, MD
Chair, Advanced Webinars

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Register online at: http://www.registration123.com/ishrs/07WEBINARS/

Upcoming Webinar

Quality Assurance and "Six Sigma" Strategies in Hair Transplantation

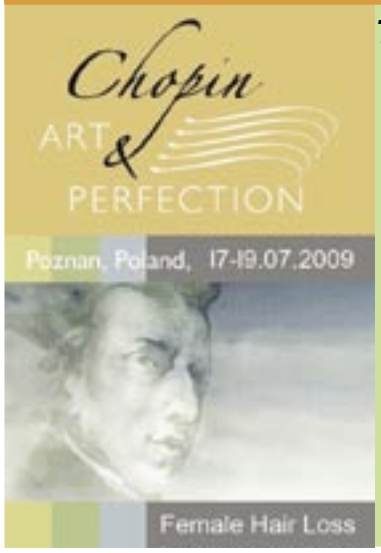
Saturday, January 31, 2009, 10:00AM–1:00PM (Central Time/Chicago) • Director: Carlos J. Puig, DO

Quality assurance is a planned and systematic set of activities to ensure that the critical steps in a procedure are clearly identified and assessed and measures are taken to ensure that these steps meet the benchmarks to provide the patient with the optimal outcome. Preventable errors can lead to complications and poor patient outcomes. A strategy known as "Six Sigma," which reduces defects in a process to fewer than 3.4 per million, may be applicable to hair transplantation. This course will describe the underlying causes of error and provide suggestions for important changes that may include adopting new educational programs, devising strategies to increase staff awareness, and encouraging physician commitment to quality improvement.

Learning Objectives:

- Describe the difference between Quality Assurance (QA) and Six Sigma quality improvement programs.
- Define and list a "critical to quality" step in hair transplantation.
- Outline the steps in implementing a Six Sigma quality program.
- Define and contrast an internal and external customer.
- Define and contrast a stable and unstable process.
- Describe the role of variation in managing quality.
- Define profound knowledge.

Save the Date: July 17-19, 2009



The weekend prior to the ISHRS Amsterdam Annual Meeting.

An optional Krakow Tour is being offered July 20-22

to bridge between the Poznan workshop and

ISHRS Amsterdam meeting.

ISHRS Regional Workshop
Hosted by Jerzy R. Kolasinski, MD, PhD

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www.ishrs-chopin.pl

Surgical Assistants Editor's Message

Laurie Gorham, RN *Boston, Massachusetts*

Greetings Assistants,

Hope everyone had a great holiday. Happy New Year to everyone. I'm looking forward to the new year and what it brings. Amsterdam will be a blast and we will again meet and exchange ideas, as well as see new faces among the old, knowing that all the while our family of assistants is growing and blossoming into a network of phenomenal information. Time flies and if you have articles to submit to the Surgical Assistants Corner, send them my way.

Happy New Year Assistants!

Laurie

laurieg@bosley.com

Message from the Surgical Assistants Chair of the 2009 Annual Scientific Meeting

Tina Lardner *Greenwood Village, Colorado*

Happy New Year!

It's hard to believe 2008 came and went! Before you know it, the 17th Annual Scientific Meeting in Amsterdam will be just around the corner. I already have commitments from doctors and assistants from around the world who will be involved in the surgical assistant's program. There is still plenty of time to get involved either by giving a presentation, submitting pictures or pearls for the workbook, contributing to the Forum, or voicing your opinion for the coming conference.

This year's meeting will cover topics geared for the novice and experienced. We will have presentations covering new developments in our field as well as practical, important information. For something new, the other part of the program will be held in a smaller group setting, where we will have presentations, visual aides, discussions, and handouts, with topics ranging from cutting, placing, training, pre-/post-op, and non-surgical alternatives. This will give us a chance to share ideas and develop friendships.

If you would like to be a part of this year's program or have any suggestions please email me at tlardner@aol.com.

Sincerely,

Tina Lardner Chair, ISHRS Surgical Assistants Executive Committee

May the New Year bring you and your loved ones peace, happiness, and good health!

Patient-centered care

Joanne Scannell, RN, Transplant Co-ordinator, Hair Restoration Ltd. Blackrock Clinic Co. *Dublin, Ireland*

Maintaining consistent, patient-centred care in a busy clinic with a diverse workforce requires careful planning and procedures. Our current surgical team of 14 includes surgeons, nurses, skilled slivering technicians, and expert cutters and planters. We also have specific key positions including the transplant co-ordinator, theatre manager, and a dedicated patient welfare assistant. Among our team we speak English and four other European languages. We perform a hair transplant procedure on a single patient daily. As of this writing, our clinic includes two operating rooms at present as well as an administrative office on a second floor.

With a planned move to a new, custom-built clinic, we will increase our clinic space from 118 square metres to over 800 square metres. We will have many more rooms, spread over three floors, within the new building. This will mean a doubling of our present staff head count. This expansion plan prompted a review of our communication and quality control practices. A few simple procedures have enabled us to keep communication straightforward, to clearly align the team efforts to the surgery plan, and to ensure work of uniform high quality is produced. These have worked so well for us that we would like to share them, as they may be useful in other clinics.

In advance of each surgery day, Dr. Collins and I (as transplant co-ordinator) review the patient's notes and photographs and discuss the potential plans for the operation. We also hold a pre-operative clinic the day prior to surgery, on which we familiarize the patient with the theatre staff and procedures, which puts the patient at ease in advance of their arrival for surgery. At the pre-operative clinic, we also trim the patient's hair in two 1cm² areas and take photographs of these areas. The hair follicles are examined and counted, and our estimates are prepared in advance of surgery to help with donor strip measurement. We also check the patient's weight, pulse, and blood pressure.

On the morning of the surgery, together with the patient, we agree on the exact plan for surgery. Then, to convey both the aims and the details of the surgery ahead, I write a plan that includes the following:

1. An introduction to the patient and their aims for their surgery
2. How the surgical team will achieve this through slivering, cutting, design, and planting
3. Educational material or refresher training of relevance to this case for staff

Example Plan

10/01/2008
Bob Jackson

Bob is 32 years old and having his first transplant today. He's been taking finasteride 1mg/day for 18 months, and his hair loss has improved. However, in the fullness of time, Bob is likely to go completely bald on the top of his scalp (Norwood Hamilton Class VII), as have most of the men in his family.

At the moment, Bob has a frontal tuft that he splits in the middle and combs forward as a fringe, and back, to cover the mid-scalp. While the bridge is thinning, the finasteride has improved this greatly. The frontal tuft is strong and will probably survive for many years, as his family history suggests this.

Bob's main concern is his crown and mid-scalp, his face is framed by the frontal tuft, but when he looks at himself from the side he sees baldness.

Today we'll transplant hair in an isolated forelock design. We'll place the front of our transplant just in front of the bridge and behind the frontal tuft, so that it will look natural in the future. Grafts will be placed as far back as the crown, where we will create an internal hairline. Sentinel hairs will be placed in front of the body of the transplant.

1's, 2's, and 3's will be placed randomly into the main body of the transplant in a thinning design because we're not looking for density. Bob has black hair and white skin, so we will subdivide 4's.

We won't transplant into the crown or the lateral humps, to allow for future hair loss. We'll only use 1,500 live follicular units today as Bob has a limited donor supply. Bob has been advised that, as his native hair recedes, he may need further transplantation to link the isolated forelock with the receding internal hairline.

Please cut live follicular units as you see them.

Thanks,
Joanne

The written document is copied and kept with the patient's notes. This information is circulated to every team member and kept close at hand for reference during the day. When the donor strip is being removed, the technical staff can discuss the plan and prepare themselves and their equipment. This ensures that the team is working together to help achieve the patient's objectives.

By ensuring the team receives some briefing regarding the patient and by giving the team feedback after the surgery, we build up a good relationship between the technicians and the patient. The patient is cared for as a person with respect throughout.✧

Classified Ads

Hair Transplant Surgeon

Great opportunity to work for one of the premier HT firms in the country in our existing operating/consulting facility in Las Vegas, in effect presenting you with the opportunity to direct the business in that location.
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INTERNATIONAL SOCIETY OF ISHRS HAIR RESTORATION SURGERY

Advancing the art and science of hair restoration

Upcoming Events

Date(s)	Event/Venue	Sponsoring Organization(s)	Contact Information
Academic Year 2008–2009	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*
January 31, 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/*
April 15–19, 2009	ISHRS Regional Workshop 15th Annual Live Surgery Workshop *Orlando, Florida, USA*	International Society of Hair Restoration Surgery *www.ISHRS.org/2009OLSW.htm* Hosted by Matt L. Leavitt, DO	Valarie Montalbano, Coordinator 407-373-0700 *HValarieM@leavittmgt.com*
July 17–19, 2009	ISHRS Regional Workshop Chopin: Art & Perfection: Female Hair Loss *Poznan, Poland*	International Society of Hair Restoration Surgery *www.ishrs-chopin.pl* Hosted by Jerzy R. Kolasinski, MD, PhD	Tel: 630-262-5399; Fax: 630-262-1520
July 22–26, 2009	17th Annual Scientific Meeting *Amsterdam, The Netherlands*	International Society of Hair Restoration Surgery *www.ISHRS.org/17thAnnualMeeting.html*	Tel: 630-262-5399; Fax: 630-262-1520
October 2–3, 2009	ISHRS Regional Workshop Follicular Unit Extraction *Denver, Colorado, USA*	International Society of Hair Restoration Surgery *www.ISHRS.org/FUERegWrkshp.htm* Hosted by James A. Harris, MD	Tel: 630-262-5399; Fax: 630-262-1520
November 8–9, 2009	ISHRS Regional Workshop 1st Mediterranean Workshop for Hair Restoration Surgery *Tel Aviv, Israel*	International Society of Hair Restoration Surgery *www.ISHRS.org/Tel-AvivRegWrkshp.htm* Hosted by Alex Ginzburg, MD	Tel: + 972-9-7603406 Fax: + 972-9-7408240 *alexgin2000@gmail.com*

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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, September 14-18, 2011
Anchorage, Alaska, USA

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