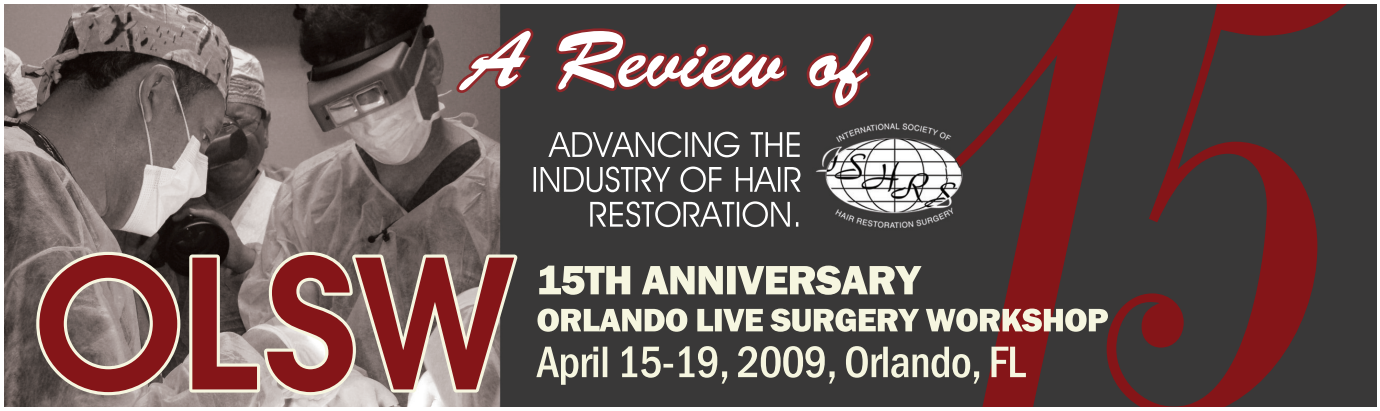

Day 1 • April 15, 2009
David Perez-Meza, MD
Orlando, Florida

This year was a very special landmark for the Orlando Live Surgery Workshop (OLSW): the celebration of our 15th anniversary! And what an amazing 15 years it has been. Almost 140 participants (between faculty, participants, assistants, and staff) were involved in the meeting and every attendee was able to bring their own unique knowledge and experiences to the OLSW. For 4 days every year, we come together with open minds and a willingness to share and learn from one another and improve for the benefit of our patients, our staff, and for the art of hair restoration procedures.

(L to R) Drs. William Parsley, David Perez-Meza, Matt Leavitt, Marcelo Gandelman

It is hard to believe how the Orlando meeting has impacted and influenced the hair restoration industry since its inception 15 years ago. At this milestone, it is important to reflect on how this annual meeting came to be, the accomplishments we've made, and to recognize the original objectives that were set forth.

In 1994, at a cosmetic surgery meeting in El Salvador, Central America, Drs. Matt Leavitt, Marcelo Gandelman, and Patrick Frechet came up with the idea to organize a Live Surgery Workshop dedicated exclusively to hair loss and hair restoration procedures. In March 1995 the vision of those three colleagues came to fruition. When the 1st OLSW was organized, it consisted of just 25 participants, myself included, and was hosted by 10 faculty members and 20 hair assistants (participants and instructors).

The meeting was a great success and that was the beginning of a tradition in the hair restoration industry.

It would take several pages to describe what has happened every year at the "Annual Orlando Hair Boot Camp and Hair-a-Thon," as these meetings are so lovingly called, for they are packed with an intense quantity of information taught over a 1-week span. For patients, faculty, and participants, there is no time for theme-park revelry or basking in the Florida sun—just hair, hair, and more hair!

Every year the meeting is organized for beginners, intermediate, and experienced surgeons. The panels with real interaction between the faculty, participants, and live patients are one the highlights of the meeting every year. Also the interactions between the surgery teams and audience coordinators are critical for the meeting's success including the different variety of surgery cases. Patient participation has been invaluable for the success of the meeting.

Organizing the meeting and making improvements every year is a team effort that includes Dr. Matt Leavitt (Chairman and Founder), Valarie Montalbano (Program Coordinator), Dr. David Perez-Meza (Co-Chairman), Dr. Mel Mayer (Scientific Coordinator), and most recently, Dr. Marco Barusco, who joined the team as Scientific and Patient Coordinator. The team also includes the entire faculty and their nurses, Medical Hair Restoration doctors, technicians, Audio-Visual group (the 52" plasma HD TV's were great addition for the viewing the operating rooms), graphic design department, Medical Hair Restoration surgery center, etc. Special thanks to all the sponsors that for the past 15 years have supported the meeting.

We have had faculty and participants from more than 50 different countries worldwide, coming from 5 continents. For the past 15 years more than 240 surgery cases have been demonstrated and more than 45 research study protocols have been initiated at the meeting and continued at the HR offices for significant statistical value. Everyone knows in the hair restoration community that if you want to teach and/or learn about hair loss, surgical techniques, new tricks, etc.: Orlando is the place to be.

Beginners Program

This session is very important for the real beginners in HRS; every year 30%-40% + of all the participants come to Orlando for their first meeting ever related to hair loss and hair restoration. This year we focused on basic concepts related to hair loss and HTS. Drs. Bill Parsley and Perez-Meza moderated the session.

Dr. Perez-Meza created the title and lecture "Hair Restoration for Dummies" Guide for Beginners as an orientation to all the new doctors interested in HRS. This year, he summarized in 20 minutes all the aspects related to hair loss and hair transplant surgery. He pointed out that there have been many changes in hair loss and HTS within the last 12-15 years that have given patients better medical as well as natural surgical results. He mentioned the importance of TEAM work at the HTS offices including the surgeon's leadership. He pointed out that there is no "gold standard" in HRS: Every patient is different and as surgeons we need to customize our techniques and treatments (medical and/or surgical) for each patient. He also discussed the surgery sessions—from small, medium, large, mega, super mega, giga, and tetra session to supersize or "superhair me"; and surgery costs—by graft, hair, session, and by cm^2 of donor tissue. The price per graft varies in the industry from $1-$6 + USD, but he did point out that a higher

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price doesn't necessarily mean a better result and vice versa.

The use of different instruments for the creation of the recipient sites (needles vs. blades) was also discussed. Dr. Perez-Meza pointed out that dense packing doesn't mean dense growing. He recommended to the beginners to stay in the "comfort zone" with 25-35 sites per cm^2. He also suggested attending the ISHRS, ESHRS, or other meetings as a supplement to their OLSW session, for the additional knowledge that could be attained from multiple experiences and different lectures. Dr. Perez-Meza also suggested several books and journals related to hair loss and hair restoration surgeries. He closed to the "newbie" crowd: "Do not panic, start with small sessions, and continue to read and learn as much as you can."

Beginners Program: Drs. William Parsley, David Perez-meza, Robert Leonard, and John Gillespie

Hair loss diagnosis in men and women is a difficult task in our practices. Dr. Robert Niedbalski reviewed the methodology for evaluating the patient with hair loss, from scarring to non-scarring alopecias. He noted the need to ask the patient some basic questions: onset, acute vs. chronic, nature of progression/regression, previous medical work-up, and obtain a medical history. The next step to take was observation: patient disposition/mental status. What is the pattern of hair loss? Focal or diffuse? Does it resemble MPHL or FPHL? Is there evidence of previous injury of the scalp? Dr. Niedbalski pointed out the importance of the scalp and hair examination including the hair pull test, scalp biopsies (2-4mm each) and lab work. He also described the importance of using the video-microscope (magnification 20-50 ×) to evaluate degree of miniaturization. He finished with the following key points: be methodical in your approach to each patient, make a proper diagnosis, don't hesitate to get a biopsy, and get a second opinion if necessary.

The initial consultation is by far the most important aspect for the hair restoration surgeon, as Dr. Robert Leonard mentioned, and the doctor must determine if the patient is medically and/or psychologically healthy enough to undergo cosmetic surgery. It is important to know personal and medical history. He pointed out that it is during the consultation where critical information needs to be discovered and discussed, including allergies. Dr. Leonard spoke about the importance of patient expectations, the progressive nature of MPHL, and donor availability to accomplish the goals.

Drs. Ursula Halsner, Grant Koher, and Michael Beehner

Hairline design is critical before starting surgery and should be part of the consultation, as Dr. Parsley mentioned. He spoke about the three primary reasons why most of the hair restoration surgeons draw a design during consultation: 1) to determine if the design is pleasing to the patient; 2) to make sure that the design is natural; and 3) to ensure there is enough permanent donor supply to meet the needs of the design and also for future hair loss.

Painless and effective anesthesia is a challenge for the hair restoration surgeon according to Dr. John Gillespie. He discussed the use of low concentration, low dose anesthesia, which is safer, less painful, and more effective. He uses Lidocaine 0.2% with 1/500,000 Epinephrine to anesthetize the donor area, and with this concentration the anesthesia is profound and lasts about 6 hours. He recommends not to use premixed Lidocaine with Epi. He starts by adding 0.5ml of Epinephrine to a 50ml vial of 1% Lidocaine; this solution will then have a concentration of Epi 1/100,000, they are always diluted with saline, usually by 5-10 times, and he also buffers the solution with sodium bicarbonate. Dr. Gillespie doesn't buffer the hairline anesthetic solution. He pointed out to make painless injections and not overdose the patient. He also recommends the use of 30-gauge needles and the slow motion technique. Sometimes the hairline needs to be reinforced every 2-3 hrs.

Dr. Parsley spoke on donor estimation, donor harvesting, and donor closure. He mentioned that for the recipient design to be completed, the proper number of grafts must be harvested, and before the strip is taken, a donor density count is needed in order to take the proper length and width. He mentioned the different devices for donor density counts and he emphasized reducing the percentage of transection during donor harvesting. The different methods for donor harvesting were discussed, including blind harvesting (feeling and listening for transection), semi-blind (excision while using a skin hook), open (scoring and then dissecting from surface to the SQ), score and spread (first scoring 1-2mm deep and then using a spreader to separate), and the FUE technique (using a small punch [0.75-1mm] to remove the follicular units). He also stressed removing the donor tissue with as little abuse, drying, and transection as possible. He mentioned the different methods for donor closure: 1, 2, or 3 layers, and the popular trichophytic technique.

Dr. Alex Ginzburg then noted that graft preparation and placement are critical steps during the hair transplant surgery procedure. He discussed the different cutting devices (Persona double edge razor blade, Persona plus single edge razor and #10 or #11 Persona blade); instruments (straight or curve forceps); and magnification used in modern HTS and graft storage containers. He spoke about the value of the microscope for better visualization and for reducing the transection rate. He pointed out the importance of placing the grafts in a container with saline or other solutions; he also mentioned some solutions for graft preservation that contain nutrients and essential amino acids.

Dr. Michael Beehner discussed the approach to the recipient area. He pointed out the advantages and disadvantages of using single or multiple follicular units, and that the "combination approach" can offer the best of both worlds: naturalness at the edges and non-see-through density throughout. As an experienced surgeon, Dr. Beehner spoke about major factors (patient's age, goals, donor availability, medical health, expectations, hair characteristics, etc.) and minor factors (family history of MPHL, thickness, elasticity, and laxity of the scalp, etc.) to keep in mind when approaching the patient. He mentioned two philosophies: dense pack a smaller area or transplant a lager area over 2-3 sessions. In his opinion framing the face is the most important goal of hair transplantation. Other important goals are natural results and sense of trust and communication with the

patient. He also discussed his approach for the hairline, frontal, mid-scalp, and crown areas including the temple points. His final pearls: imagine worst case scenario, be certain of your expectations, hairline placement is crucial, make acute recipient sites and avoid pitting and, finally, when the patient is "too bald" or "too young," use a forelock pattern.

Pre- and postoperative instructions (including consent forms) were discussed by Dr. Vincenzo Gambino. He emphasized the importance of having an educated and informed patient. He pointed out that to avoid legal problems we (the surgeons) must have a clear and concise consent form outlining all the possible foreseeable and unforeseeable possibilities during and after the surgery that is explained to the patient and then signed in front of witnesses. He also pointed out to review with the patient the pre- and postoperative instructions and to answer any questions the patient may have.

Complications in HRS are part of the surgery, as Dr. Perez-Meza mentioned. He said no surgeon is immune. He pointed out the importance of a good surgical plan and good surgical technique for a successful result. He reviewed the goals in dealing with complications: correct the problem or defect, avoid recurrence, and prevent them altogether. He pointed out that a complication is a surgeon's responsibility and we also need to learn to say NO to patients in whom we anticipate problems. Sometimes, the best surgery case is when there is no surgery. He described the worst mistakes that a surgeon can make: minimize or deny that a complication exists; be inaccessible to the patient; and demonstrate anger toward the patient. He summarized that if a complication exists, the most important thing is to give "support" to the patient; this will avoid many legal problems and he repeated that prevention is always the key.

Dr. Marco Barusco discussed staff training as being critical in HRS for obtaining good results. The staff includes the receptionist, office manager, and surgical technicians. He also mentioned that the staff gives the first impression of a hair restoration office. He pointed out that surgeons should participate and take an active role in the process of selecting, training, and providing quality control for our technicians. He concluded that nothing is more valuable than a well-trained staff.

Dr. Carlos Puig spoke on "Ethical Consultation and Its Impact on Industry Growth." He mentioned that the purpose of the consultation is to educate the patient with ethical responsibility and to ensure the patient's autonomy and to maintain fidelity. He pointed out that it is also very important that the patient fully comprehends what we are saying during the consultation, including the pathophysiology of hair loss, physiology of the procedure, and the general risks and associated benefits. Dr. Puig also recommended following professional marketing standards including before & after photos (same lighting, same angles, filters and no touch-ups). In addition, he discussed the industry immaturity with multiple types of product and services, multiple names for the identical procedures, and poorly defined industry standards; all of these creating consumer distrust of product services. He finalized with the steps toward industry maturation and the important role played by the ISHRS and ABHRS.

Female Consultation Panel: Drs. Sharon Keene, Valerie Callender, and Matt Leavitt with a female patient.

Dr. Leavitt concluded with his "pearls" in HRS. He mentioned that patients have become increasingly informed and sophisticated regarding hair loss and transplantation. They research the procedure, scrutinize the Internet, participate in message boards, and interview various physicians until they reach a level of comfort. Dr. Leavitt noted that excellent hair transplant surgery alone may not be enough for a patient to commit to surgery or to stay with a practice for subsequent surgeries. He discussed in detail the non-surgical or non-medical factors that impact patients' perception of the surgical experience. Dr. Leavitt concluded with the thought that excellent surgical results should be expected and received by every hair transplant patient from any physician they choose. The difference in long-term satisfaction often may be subject to how well the "customer service" aspect of their selection process is perceived from the time of consultation through the entire surgical experience and post-op course.

At the end of the first day the participants of the 15th Annual OLSW walked away with a deep appreciation for the knowledge that was shared.

Day 2 • April 16, 2009
Robert Niedbalski, DO *Bellevue, Washington*

The day began with Dr. Matt Leavitt reminding us of the OLSW mission statement: Advance the science of hair restoration, educate hair restoration surgeons, and (most importantly) promote lasting friendships. After 15 years it is clear that the original concept of this meeting as defined in the mission statement was well thought out. Dr. Marcelo Gandelman, one of the OLSW cofounders, shared some photos of the first live surgery workshop that took place in San Salvador in the lobby of a hotel! ISHRS President Bill Parsley also gave a historical perspective. He observed the many new techniques, instruments, and concepts that have been tested here at the Orlando meeting. He summed up the concept of this meeting nicely with this proverb: "Tell me and I'll forget; show me and I'll remember; let me do and I'll understand." The last introductory speaker was the co-chairman of this workshop, Dr. David Perez-Meza (General David Perez) whose job it was to oversee the 15th annual "Hair Boot Camp." The General reminded us of the unique experience: having so many experts available individually to each workshop attendee. The goal of this "Hair-a-Thon" was to "raise the bar" of excellence and learning for both teachers and trainees.

Panel 1: Female Consultation. Moderator: Dr. Matt Leavitt; Panelists: Drs. Sharon Keene, Valerie Callender

Dr. Leavitt reviewed the significant psychological impact of hair loss in women as compared to men. He also pointed out that female hair restoration patients can represent a significant growth segment in our practice. He discussed the top 4 causes of alopecia in women: female pattern alopecia (FPA), telogen effluvium (TE), traction alopecia (TxA), and scarring alopecia (SA). He noted the most important challenge being the distinction between (FPA) and (TE), which can look disarmingly similar. He noted the following points: look for a slow progression and miniaturization with FPA; warn the patient about postoperative TE (which is unpredictable and may

be significant); and educate the patient on how to camouflage this temporary problem. The panel met the patient, an African American woman with frontal and bitemporal thinning. They discussed the differential diagnosis and the consensus was that this woman probably had elements of both FPA and TxA. The treatment recommendations were FUT, minoxidil, and discontinuation of hair braiding. She would likely need a second procedure in the future to achieve her desired hair density in the treatment areas.

Panel 2: Male Consultation. Moderator: Dr. Robert Cattani; Panelists: Drs. Robert Leonard, Tony Mangubat, Bill Parsley

Dr. Cattani improvised a Q&A session with the physician panelists. The queries focused on what mattered most to both the physicians and male hair loss patients including:

- How men found and decided on which doctors they would see for a consultation
- The impact of physician marketing on this decision
- The importance of price in deciding who they would ultimately choose
- Whose opinions factored into their decision—spouse, friend, significant other, hair stylist, etc.
- Which techniques the doctors preferred when performing hair restoration surgery
- How effective physicians felt their marketing efforts were
- What the physicians felt mattered most to patients

This approach brought to light the wide range of concerns and variety of preferences that balding men have.

Panel 3: Hairline Design. Moderator: Dr. Bob Leonard; Panelists: Drs. Antonio Ruston, Michael Beehner, John Gillespie

Dr. Leonard introduced the patient who had significant frontal and bi-temporal thinning. Some of the panelists prefer to draw the hairline themselves as opposed to giving the marker to the patient. They feel that this sets the "bar" at a level they have room to negotiate from. The panelists then reviewed the facial landmarks commonly used to define the boundaries of a new hairline: the temporal recess and the low point of the hairline on the forehead. A key element stressed by the panelists was working hard to communicate the "visual line" the patient will see when the transplant has grown out. The details of creating "naturalness" in the hairline were unique to each panelist though a common thread was the importance of studying hairlines in non-balding subjects with different features.

Hairline Design Panel: Dr. Antonio Ruston marking the hairline in a male patient.

Panel 4: Donor Harvesting Preparation and FUE. Moderator: Dr. Mark Di Stefano; Panelists: Drs. Tony Mangubat, Matt Leavitt

Dr. Di Stefano discussed the Harris 2-stage punch system that uses a sharp initial punch to penetrate to the dermis and a dull punch to separate the rest of the follicle with the intent of minimizing transection. This method is very popular for removal of scalp hair, but for body hair extraction, Dr. Di Stefano prefers the use of a 0.8mm single action fixed punch. He often shaves strips in a layered fashion for surgeries of up to 800 grafts, which makes the patients much happier than when large continuous areas are shaved.

Dr. Barusco reviewed a 2-layer donor closure technique he and Dr. Leavitt use (The Leavitt Zipper). The subdermal layer is closed with a running suture of Biosyn (3 or 4-0) chosen for its elasticity and non-tissue-binding properties. He then closes the skin with a nylon or Prolene (3 or 4-0) running stitch through the upper dermis. The subcutaneous layer reapproximates the tissues so the surface layer has virtually no tension so it minimizes scarring. This is a great technique to use when excising old donor scars.

Dr. Mangubat demonstrated how he uses the following time-saving techniques to improve his speed and efficiency when performing hair transplant surgery:

- *Multi-bladed knife used to extract 1 FU-wide donor strips.* He emphasized there is a steep learning curve with this technique and that improper use can result in a "follicular holocaust" and ultimately a poor surgical outcome.
- *Staples used for wound closure.* Single layer and very fast compared to sutures.
- *Impulse Force Graft Cutter device used to produce grafts with minimal microscopic dissection.* The mechanism was demonstrated nicely in video format showing the individual donor strips (1-2 FUs wide) laid over a bed of Persona cutting blades aligned perpendicular to the hair shafts. The blades are spaced 1-2mm apart. When covered with a tongue depressor and rapped with a rhinoplasty hammer, the strips were forced over the blades to produce grafts of roughly 1-2 FUs in size. The transection rate is noticeably higher than with microscopic FU dissection, however, Dr. Mangubat says he can produce 2,000 grafts in 30 minutes and gets very nice results (and satisfied patients).

Panel 5: Donor Closure & Trichophytic Method. Moderator: Dr. Bill Parsley; Panelists: Drs. Carlos Puig, Alex Ginzburg, Glenn Charles

Dr. Puig developed the Ledge Knife for trichophytic closure, which makes the trichophytic incision before removal of the donor strip. This scalpel device has a depth and width control making the trichophytic incision more consistent in width and depth.

Dr. Ginzburg described a technique for dealing with widened donor scars by creating a Running W-Plasty saw-tooth incision of 1.5-2.0cm segments. He then undermines and closes the subcutaneous layer with interrupted 3-0 Monocryl sutures and runs a 5-0 Nylon on the skin.

Dr. Charles uses a running 3-0 Dexon suture in the subcutaneous layer and 4-0 prolene on the skin.

Dr. Parsley described his method, which is similar to that of Drs. Barusco and Leavitt: 2-layer closure using 4-0 Biosyn in the subcutaneous layer and 4-0 Ethilon on the skin. A common thread among these closure methods is the care taken not to strangulate tissue with these running sub-q sutures. There is a danger of post-op TE in the donor area due to vascular compromise from too much tension on sutures. Likewise, taking care to penetrate the dermal layer at the depth of the trichophytic incision (about 1mm) will also minimize follicular damage in the closure.

Panel 6: Hair Transplant in Other Areas. Moderator: Dr. Marcelo Gandelman; Panelists: Drs. Ali Abassi, Tommy Hwang

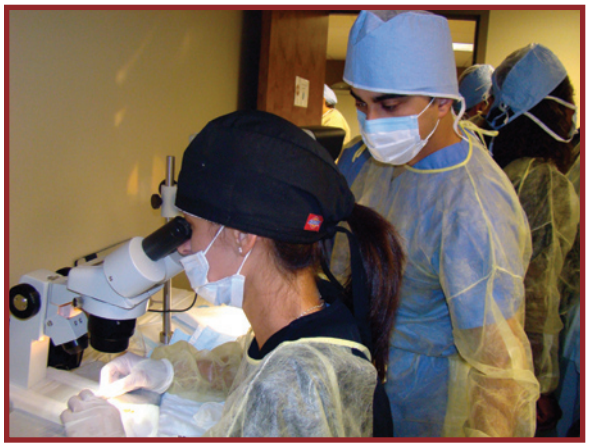
Dr. Gandelman has been performing eyelash and eyebrow transplantation for many years and offered his pearls of wisdom

for this highly specialized niche of hair transplantation. Patients seeking eyebrow and eyelash transplantation have a higher incidence of body dysmorphic disorder (BDD) and trichotillomania (TTM). Untreated/undiagnosed BDD or TTM are contraindications to performing lash/brow restoration. Dr. Gandelman often recommends a background tattoo for female eyebrows as this allows for a more refined line and requires fewer transplanted hairs. Eyelash transplant patients will need to be counseled about the requirement for daily grooming of transplanted eyelashes. He also described the technique of reverse donor harvesting for eyelash hairs by creating a small flap in the donor area and teasing the follicles out from below the surface. This obviates the need to trim epidermis from the grafts and facilitates proper placement of these hairs into the lid. Lastly he mentioned the increasing prescription use of Bimatoprost (Latisse) that when applied topically to the eyelid will stimulate the growth of longer eyelashes (presumably by lengthening the anagen phase). There is a risk of increasing pigment in the surrounding tissue and this raises the question of whether there might ultimately be an increase in the risk of developing a melanoma.

Dr. Abassi reviewed his technique for eyelash transplantation that emulates the natural growth pattern of lash hair. They grow in 3-4 rows at the tarsal ledge and total 300-400 hairs for the upper and 100-150 hairs in the lower lid.

Dr. Hwang presented his findings from transplanting his own scalp hair to various areas of his body to study recipient site influence on transplanted hairs. He was able to demonstrate a change in the growth characteristics of these hairs as being influenced by the recipient site (e.g., chest hair transplanted to the scalp grew longer than it did on the chest and scalp hair ultimately grew shorter when transplanted to the pubic area). In scalp transplants the recipient site has very similar growth characteristics as the donor scalp so there is no perceived difference in the growth of the transplanted hair.

The next stop was the Lake Faith Surgery Center for an afternoon of demonstrations of all the techniques described above. Five surgery cases were demonstrated: 1) follicular unit transplantation and FUE case; 2) female case with donor zipper closure and trichophytic closure; 3) follicular unit transplantation with donor closure and low concentration of local anesthetic demonstration; 4) eyebrow case; and 5) eyelash surgery case. Cutting stations and the cadaver workshop demonstration with "hands-on" activities were set up for doctors and assistants. It was a very interesting and exciting day for participants.



Cutting Station: Participants view the graft preparation under the microscope.

Day 3 • April 17, 2009
Gabriel Krenitsky, MD *Columbus, Ohio*

Friday began with a variety of panel discussions that demonstrated an open-mindedness that has at times been lacking in meetings. The session was a great example of the true variety of ways there are to make people look great, and feel better.

Dr. Bill Parsley kicked off the morning with a nice review of the various nomenclatures (sagittal-coronal, perpendicular, parallel) and a refresher on what everything means. Dr. Sharon Keene added a discussion of DFUs (double follicular units), and when to incorporate them into a surgical plan. Dr. Robert Niedbalski's way of thinking about hair dimensionally was very intriguing. He explained the dimension we see hair varies at different distances, and how as surgeons we can replicate those dimensions by creating macroscopic and microscopic convergence with the graft sites.

In the New devices and Systems section, Dr. David Perez-Meza demonstrated the FotoFinder system and the Trichoscan imaging technology with its different uses, such as the diagnosis of hair loss patients (female and male), hair loss clinical research, and patient selection for HRS. He pointed out the value of the system measurement of hair diameter, anagen-telogen ratio, hair density, and for the search of telogen hairs. Dr. Marco Barusco talked about his experience using a needleless anesthesia injector that he later demonstrated.

Additional highlights focused more on the human aspect of the techniques we use. Dr. Marcelo Pitchon had a tremendous video of patients seeing themselves for the first time after using a preview hair transplant technique where the hair is transplanted long. Dr. Barusco's patient's new beard had proudly earned him the nickname "wolverine" because of color contrast of his scalp donor hair and existing beard hair.

Dr. Sharon Keene poignantly dispelled some of the Internet myths on dense packing and hair density, in particular pointing out that true frontal hairline densities average 40-50 FUs per cm^2, and are quite achievable in many patients.

There were 4 surgeries that highlighted the afternoon. The Cadaver Workshop was ongoing and was a great way to practice some skill sets. The frontal forelock surgery performed by Drs. Ricardo Mejia, Mike Beehner, and John Gillespie was a great demonstration of the integration of incision sites, sizes, and angles. The site size range varied from punch grafts to Minde blades (0.8-1.8mm) in size. Closing with 3-0 Vicryl and 3-0 Prolene, a traditional 2-layer closure was performed. I really enjoyed seeing the finished product on this case because having the ability and judgment to incorporate the best of the older techniques and the latest advances is truly an art that was well demonstrated.

Drs. Ron Shapiro, Edwin Epstein, and Robert Niedbalski did a great job with a dense packing demonstration that again uses various blades as well as a trichophytic closure. Hair was aggressively transplanted to the mid-scalp to improve the patient's density in this area. Dr. Gabriel Krenitsky demonstrated the TrichoSave closure where by a lower ledge technique is modified in such a manner as to remove the epidermis but leave the hair shafts below intact. The wound was then closed with a "zipper" technique using 4-0 Biosyn with a superficial layer of 3-0 Nylon.

Finally, Drs. Charles and Barusco, working on an African American woman, demonstrated the needleless anesthesia injector with great results, a double layer closure with 3-0 Dexon and 4-0 Prolene, and site variation ranging from Minde 1.3-1.8mm in size.

Friday's session was informative, interesting, and demonstrated novel techniques, as well as some tried and true techniques that have served doctors and patients well for years.

Day 4 • April 18, 2009
Ricardo Mejia, MD *Jupiter, Florida*

The Complications panel was moderated by Dr. David Perez-Meza, who reminded us to be supportive with patients when dealing with these issues but that the most important aspect is how to prevent them. It was mentioned that the complications in the donor area were most noted around the mastoid area, which is subject to significant tension.

Dr. Bill Parsley followed with postoperative bacterial infections. With the high incidence of MRSA infections it is recommended to culture any pustular lesions. Treatment with Doxycycline 150mg for 3 weeks was recommended.

Dr. Mark Di Stefano presented a case of follicular unit extraction (FUE) complication with poor growth, postsurgical effluvium, and delayed temporary thinning. The problem most noted with FUE was folliculitis; however, another major concern was over-harvesting the donor area, which could result in significant telogen effluvium.

Dr. Asim Shahmalak presented a patient with multiple scars in the donor area. The key to a successful outcome is to ensure proper skin laxity. Undermining the upper and lower edges of the incision assists in reducing the skin tension. He utilized a 2-layer subcutaneous fat closure. Language barriers also present unique challenges, and it was advised to have pre-op and post-op instructions in a patient's native language to avoid miscommunication.

Dr. Marco Barusco presented a complication (necrotic area and scarring) in the center of the frontal area related to the prolonged pressure of a headband.

Dr. Antonio Ruston focused on minimizing complications in smokers by decreasing epinephrine concentration to 1:500,000 as well as advising patients to decrease cigarette smoking to three cigarettes per day or quitting three days before and three days after to avoid necrosis. He advised using postoperative minoxidil and to avoid dense packing.

Dr. Tommy Hwang followed a discussion on eyebrows and eyelashes and the complications that can result with the unnatural growth of hairs traveling in different directions through scars. Dr. Hwang also recommended the use of 3M adhesive spray to the pubic area to prevent the hair follicles from migrating deeper into the recipient sites, which can cause epidermal cysts.

Dr. Ricardo Mejia presented a complication case that was recently published in Oral and Maxillofacial Surgery Clinics. (2009; (21)1:119-148) by Drs. Perez-Meza and Robert Niedbalski regarding elliptical excision techniques to remove low lying plugs in the temporal triangles. He also presented a workshop case done a couple of years ago with Dr. Sheldon Kabaker. A row of hairline plugs was excised followed by scalp advancement. The importance of working with colleagues to ensure successful outcomes is of utmost importance.

The next session was moderated by Dr. Mejia. Dr. Bill Parsley presented the results of his "on-site doctor volunteer study" utilizing various different camouflage treatments for hair loss. He presented before and after photos that were taken with the FotoFinder system. It was his opinion that the sprays worked better for patients with a lot of hairs whereas fibers worked better for finer, shorter hairs.

Dr. Ken Washenik subsequently discussed emerging hair loss therapies. He mentioned a current hair regrowth study by Drs. Craig Ziering and Perez-Meza. They injected wnt proteins and different growth factors in 24 patients with hair loss, they also used scalp stimulation or perturbation prior to the injections; it is a 5-month study but there is no data available yet. Dr. Washenik did indicate that lichen planopilaris was associated with a decrease in PPAR (peroxisome proliferator activated receptor agonist) gamma. This resulted in an increase in inflammatory cytokines and a decrease in lipid fatty acid cholesterol enzymes, which raises the possibility of utilizing PPAR gamma agonists to treat scarring type alopecias.

Dr. Humayun Mohmand noted the objective evaluation of self-esteem improvement in patients following hair restoration surgery. Comparing before and after photos, he notes a difference in the eyes. Patients look more alive and vibrant from the psychological improvement of having more hair.

Dr. Valerie Callender followed with her presentation on the differences in African American hair being curlier and chubbier requiring potentially larger recipient site blades. She also focused on the benefit of transplantation in patients with follicular degeneration or centrical centrifugal scarring alopecia.

Dr. Mejia ended the session by presenting numerous cases of skin cancers that can occur on the scalp. Consequently, the most important lesson is to examine the scalp properly for any signs of cancers in both the donor and recipient areas.

The session ended and attendees moved on to more surgical cases at the surgery center. If a picture is worth a thousand words, a live surgery with a 52" Plasma HD TV is worth a thousand textbooks of knowledge. We invite each of you to attend the next OLSW.✧

Letters to the Editors

Jeffrey Epstein, MD *Miami, Florida*
Re: Premature Reporting of Techniques in Hair Transplantation

I think that, with almost 15 years of active involvement in the wonderful field of hair transplantation (and almost 20 in facial plastic surgery), I have seen and done enough to provide worthwhile commentary on trends in the field. Just recently, I have read reports on two different new techniques in hair transplantation, one that appeared in the March/April *Forum* (Laorwong, K., et al. Eyebrow transplantation using donor hair from sideburns. 2009; 19(2):54) and another that appeared in several online forums (the NeoGraft FUE harvesting and planting system) that were premature in being presented. Let me elaborate.

The single report, by the respected colleagues from Thailand, of one patient who had a total of 84 grafts placed to the eyebrows was, in my opinion, flawed in several aspects. Having performed over 200 eyebrow transplant procedures in the past 4 years, with my experience reported in an article I had published in the *Forum* (2006; 16(4):121-123), I have learned that the most natural appearing results, especially when restoring the tail of the eyebrows, is achieved with the use of finer—not coarser—hairs. These finer hairs tend to lay better, and thus look more natural and create more manageable brows. Also, the skinny dissection of the grafts as pictured in the article usually results in a lower rate of growth, and furthermore, is not necessary, for these single-hair grafts are easily planted into recipient sites 0.5mm in size—smaller in fact than those achieved with the described 22g needles. In the patient pictured in the article, two to three times the number of grafts transplanted would be indicated to achieve any sort of reasonable density. Most disappointing, however, with this article is that the surgeons reported on the "results," and the patient's "satisfaction," at just 5 days post-procedure, which is completely premature for making any sort of conclusions.

The other report with which I have concerns is the presentation of the NeoGraft system as being superior to traditional FUE harvesting techniques. We all know that the two key factors in poor graft growth, as reported numerous times in our meetings, textbooks, and this *Forum,* are traumatic graft handling and desiccation. It seems that any mechanical system that harvests grafts then draws them in, then can even implant them by an apparent air suction/flow mechanism, has the definite potential for impaired hair growth. I greatly hope that this is not the case with the NeoGraft system, but unfortunately, there has not been, to my knowledge, a single published report on the success rate of FUE transplants using the NeoGraft system—only undocumented reports by the manufacturer that in Europe the system has been used on "thousands of patients."

I so welcome new technology and developments in the hair and plastic surgery fields, but, unfortunately, have been witness to an endless number of new technologies, most of which were released with great fanfare, only to be discarded a year or two later as the touted advantages proved to be short-lived. Examples: the hair implanter carousel; thread lifts for facial rejuvenation; Thermage skin tightener; and a variety of methods for reducing donor site closure tension including electrocautery of deep donor tissue as well as "tunneling techniques." Even the initial laser hair combs and minoxidil, two innovative treatments that now have a potential role in treating hair loss, were initially released with such incredible accolades that the hype was much more than the reality—all in the name of making money, and perhaps secondarily in helping patients. Maybe when selling cars or perfume, hype and marketing can take precedence over data ("buyer beware"), but when it comes to medicine—surgery in particular—restraint must take precedence for our patients are quite trusting.

I am in no way condemning either the described eyebrow transplantation technique or the NeoGraft system, and do hope that they help advance the hair transplant field, and I have respect for the authors of both articles. I only wish that the doctors had waited to see actual final results before prematurely reporting on them and, in the case of the eyebrow article, that the *Forum* editors had used enough discretion to request longer follow-up than 5 days.

Kongkiat Laorwong, MD *Kathu, Phuket, Thailand*
Reply to: Jeffrey Epstein, MD

The main purpose of our article was to show a novel source of donor hair and the technique for selecting a donor source based on matching the caliber and texture of clipped hairs. This patient, described as a middle-aged Caucasian male, had coarse and long native eyebrow hairs, especially in the medial to middle aspect of the eyebrow, and thinner hairs at the tail. The aim of restoration was to make his eyebrows look dark and full and that is why we tried to select the donor source that well matched his existing brows. Using coarse shaft diameter hairs gives a greater impact than absolute hair numbers in determining overall cosmetic density. We used a smaller number of grafts with the purpose of achieving a better survival and growth rate as opposed to using a high density of finer hair grafts.

We recognize that the length of follow-up was too short, so we clearly stated in the article that **"long-term follow-up is required."**

⇨ page 142

Editors' Note: We encourage opinions and debate and certainly appreciate Dr. Epstein's comments. Our decision to publish the case was based on the facts elucidated by Dr. Laorwong's reply as well as the following:

1. The technique of clipping hairs from both the recipient area and possible donor areas for the purpose of matching caliber, color, and texture is novel, as is the sideburn donor source.
2. The patient was a middle-aged male and the article states that sideburn hair is "an *alternative* donor site in *some* patients."
3. Obviously, final results cannot be assessed at 5 days, but, to quote the article, the patient's "satisfaction" with the "results" was **"because the grafted hair *matched well* with the existing eyebrow hair"**; moreover, the article clearly stated that **"long-term follow-up is required."**

Letters to the Editors
from page 141

Carlos Uebel, MD PhD Porto Alegre, Brazil
Re: Dr. Bill Parsley's March/April President's Message

In Bill Parsley's President's Message about the two most important articles in the history of hair restoration (*Forum*, 19(2):42), I agree totally that Dr. Norman Orentreich created modern hair restoration, but was disappointed when Dr. Bobby Limmer was named as the revolutionary hair restoration surgeon who introduced micrografting refinements in the field. Dr. Limmer is a respected colleague and a friend of mine. He attended my lectures in 1992, maybe at the Toronto ISHRS meeting, and was impressed about my micrograft megasessions technique. He asked me for a reprint of my article and I gave him my peer reviewed paper that I published in 1991 in the *Annals of Plastic Surgery* (1991; 27:476-487)—"Micrografts and minigrafts—a new approach for baldness Surgery"—where I introduced single and unique technical procedures like "scalp ballooning," "single hair," "stick-and-place," "punctiform technique," "elliptical hair-bearing flap," etc. Dr. Limmer then published his article in 1994, similar to mine, giving credit to my elliptical donor microgafting paper in his article. This allowed us to transplant more then 1,000 grafts in 3 hours. I still use the same procedure and have operated on more than 8.500 patients. I got the idea from the papers of Nordstrom and Marrit that used micrografts (splitting punches in several parts) to hide frontal scars and burn scars. I introduced micrografts first in the 1980s for use in the front of my Juri flaps, presenting my experience at the Birmingham Hair Restoration Meeting in 1983, and after, saw that I could use them in male and female pattern baldness, and in large quantities reaching the mega-sessions. At that time nobody mentioned "follicular units" because nobody knew about the extraordinary paper published by Headginton in 1984, and so we called simple 1- to 2-hair units "micrografts" and 3- to 4-hair units "minigrafts." Only 10 years later did O'Tar Norwood revisit Headginton's article and he then brought the news to the *Forum*.

What is important is that we started with the refinements in Hair Restoration with the "micrograft megasessions" or, giving credit to Headginton, "follicular unit megasessions." I am proud of this and I am sure that we have introduced a new era for Hair Restoration Surgery and contributed with others to develop new advances in the last 20 years. By the way, I was invited by the Moser Clinic in Vienna at the end of 1991 to visit for one week to teach my technique, after which Claudia Moser presented their experiences in this field. Until today I am a Consultant of the Moser Clinique in Augsburg, Germany, for Plastic Surgery and maintain good relations with them.

I hope I could bring some important issues for your future editorials and congratulations for the excellence of the *Forum*.

With my kind regards and I hope to see you all in Amsterdam. carlos@uebel.com.br✧

Editors' Note: See Dr. Parsley's President Message for his response to Dr. Uebel's comments

Review of the

Literature: Dermatology

Marc Avram, MD New York, New York; Nicole Rogers, MD Metairie, Louisiana

Traumatic Times

Citations

Willemson, R., J. Vanderlinden, D. Roseeuw, and P. Haentjens. Increase history of childhood and lifetime traumatic events among adults with alopecia areata. *J Am Acad Dermatol.* 2009; 60:388-394.

Picardi, A., and D. Abeni. Stressful life events and skin diseases: disentangling evidence from myth. *Psychother Psychosom.* 2001; 70:118-136.

A recent study by dermatologists and psychologists in Belgium investigated whether there is an increased incidence of childhood or lifetime traumatic events in patients with alopecia areata (AA). Data on 90 adult patients with alopecia areata and 91 control patients were analyzed. The authors used a self-reported questionnaire called the Traumatic Experiences Checklist (TEC). They found that significantly more patients with AA experienced total lifetime and early childhood (age < 10) traumatic events, with an odds ratio of 2.46 ($p = .017$) and 2.16 ($p = .016$), respectively. Such events were defined as family problems (divorce, drinking, or psychiatric problems), loss of loved ones, serious bodily injury, physical, emotional, or sexual abuse, bizarre punishments, and neglect. The authors note that this study is susceptible to recall bias and confounded by stress caused by AA outbreaks. The authors propose that adverse childhood experiences reduce patients' ability to control the hypothalamic-pituitary-adrenal axis response. They have a more limited inhibition of inflammation by glucocorticosteroids. Such patients have been known to have enhanced susceptibility to stress, suffering from conditions like chronic fatigue syndrome, irritable bowel syndrome, and fibromyalgia. In normal conditions, vital structures such as the eye, the brain, and the hair follicle are immune privileged. The authors suggest that without this reduced inhibition, hair follicles lose their protection from the potentially damaging effects of an inflammatory immune response.

Comment

Alopecia areata remains one of many causes of hair loss wherein the etiology is far from clear. Several studies have already explored the connection between recent stress (last 6 months) and alopecia areata. A review of 8 well-conducted studies found only preliminary evidence that a (short-term) connection exists (Picardi and Abena, 2001). Since then 5 other case-controlled studies examined the connection between short-term stress and AA, but 4 of these found no evidence. This is the first study to show a significant link between lifetime stress and the development of AA. Their hypothesis about the effect of early traumatic events, and how they may alter the programming of normal stress responses, is very interesting. We hope that the results of this study will spur further investigation into the link between neuroendocrine responses and this condition, which can be very traumatic in and of itself.

Hair for... Lunch?

Citation

Jafferany, M., J. Feng, and R.L. Hornung. Trichodagonomania: the compulsive habit of biting one's own hair. *J Am Acad Dermatol.* 2009; 60:689-691.

One recent case report describes a 17-year-old male who admitted to biting the hair on both of his forearms, especially during periods of severe anxiety and boredom. He was seen in clinic for patches of hair loss on both forearms and had a history of comorbid depression and anxiety disorders. Microscopic examination of the bitten ends of hair showed smooth, sharply demarcated, blunted shafts. The patient did not have evidence of hair pulling, or trichotillomania, anywhere else on the body. The authors propose the term trichodagomania, from the Greek words thrix (hair) + daganein (to bite) + mania (madness). Unlike patients with trichotillomania, who rarely admit to recurrent pulling, this patient frankly admitted his urges and expressed a sense of gratification after each bite. The patient was treated with a selective serotonin reuptake inhibitor (SSRI) and habit reversal therapy with substitution techniques.

The authors mention two other unusual causes of hair loss:

Trichoteiromania = compulsive rubbing of hair to produce a patch of hair loss. Ends of hair shafts are noted to have brush-like ends.

Trichotemnomania = compulsive cutting or shaving of the hair.

Comment

Patients with underlying psychiatric or psychosomatic conditions are some of the most difficult to treat for hair loss. They are usually unaware or unwilling to admit to their habits and may even become defensive with any suggestion that the hair loss is self-induced. It is essential to develop a good rapport with these patients, and then encourage them to seek the help of other trained professionals in changing their habits. Suggesting that patients are "pulling and not even aware of it!" makes this condition easier for them to accept and understand.✧

Surgeon of the Month: Robin Unger, MD

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


Robin and her girls

Robin was born in 1968 in Toronto, Canada. She was the third eldest of 11 children, three of whom tragically died in a home fire when she was 7 years old. Her father Walter was a dermatologist and her mother Marcia was a stay-at-home mother managing a large family (nearly a small village). Her family had a strong medical background. Three great uncles were physicians and together with her grandfather, they built the first private, not-for-profit hospital in Canada. Her uncles on both sides of the family were also doctors, and now her two youngest siblings have joined the illustrious profession. Robin split her time between Toronto and a family hobby farm in Mansfield, where she spent weekends skiing, horseback riding, and playing with the animals on the farm.

Robin attended high school in Toronto and then began her many years of travel/education with her first year of University at New College, Oxford University. She then transferred to McGill University in Montreal where she graduated with a double major in political philosophy and economics. During the summers she did research in anesthesia and traveled extensively throughout Europe. She took a year off (or a "year on," in retrospect) to work with her father in Toronto as a medical technician, learning the details of hair transplant surgery. The following year, Robin moved to New York City where she continued to work with her father, part-time, as a technician and office manager and part-time in the fashion industry, while she was still deciding what she wanted to do with the rest of her life. Eventually, it dawned on her that being a medical doctor might be what she was looking for after all. She enrolled at Columbia University doing a post-baccalaureate in pre-med.

In 1996 Robin began her studies at Sackler School of Medicine, Tel Aviv University, and when she graduated in 1999, she moved back to New York. Her residency in ophthalmology at North Shore-Long Island Jewish proved a wonderful experience. That same year she met her husband, Raul Hernandez, a surgical resident at the same hospital. Their romance bloomed quickly, but unfortunately he was diagnosed with cancer within a short time. In early 2000, her father presented her with one of her greatest blessings—he offered her a partnership in his practice in hair transplant surgery in New York City. This allowed her to have a very flexible schedule and spend the majority of her time with her ailing husband, including a three-month honeymoon in Canada, Spain, and Portugal. It was a priceless gift, for which she will always be grateful. In May 2002, after a long and gallant battle, Raul passed away.

Robin has been in practice as a hair transplant surgeon in New York City for the last 9 years and has a very unique perspective, given her previous experience as a hair transplant technician and the "cheat sheet" to surgical planning provided by her father's long history in the field. Her practice has flourished, with almost 40% of her patients being female and a substantial number being men with early stage MPB. Both populations have recipient areas with pre-existing hair. Rather than being a deterrent, Robin utilizes this trend to her advantage, allowing the flow of pre-existing hair to guide her in creating the recipient sites. Although it was not her initial intent to become a hair restoration surgeon after completing medical school, she has found it to be an incredibly gratifying field. The almost old-fashioned patient-doctor relationship, in which the two really get to know one another, is refreshing in these modern times. In addition, she is constantly rewarded by the gratitude expressed by patients on a nearly daily basis. Patients regularly tell her, that since their transplant their life has been transformed; a constant worry and insecurity is just magically no longer a preoccupation. Robin and Walter share a new office in New York, with Dr. Carlos Wesley, which is fully certified and accredited. She is an Assistant Clinical Professor at Mt. Sinai School of Medicine, where she regularly teaches the art of hair restoration surgery to dermatology and plastic surgery residents and fellows. In addition, she is currently pursuing several areas of research, including one on graft preservation and a second on the treatment of recalcitrant alopecia areata with hair transplant surgery. Both are showing promising results.

Robin has tried to give back to the community in whatever small ways she can. Throughout high school she volunteered at a home for the aged and during medical school she volunteered her services at a clinic for Ethiopian refugees. In 1998 she spent several months at a mission hospital in Kwazulu Natal, South Africa, working with an impoverished, medically-deprived population of patients. Robin is currently a volunteer with the ISHRS's OPERATION RESTORE and is "on call" for the burn unit at Mt. Sinai Hospital.

Robin's love of languages has helped her become fluent (at one time or another) in Spanish, Hebrew, and French. Throughout her time in the hospitals she was often called upon as an interpreter, introducing her to very interesting cases that otherwise she would have never encountered. Among her hobbies, Robin enjoys skiing, hiking, scuba diving, roller-blading, travel, and reading.

In September 2008, Robin gave birth to her and Raul's "miracle babies"—Nicole Muriella and Rafaella Amanda—the third and fourth grandchildren for both sides of the family. They are now 8 months old and together with their dog, Sherwin, this happy family spends time on the swings in Central Park and going for long walks all over New York City.✧

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

Tina Lardner *Greenwood Village, Colorado*

Hello everyone! By the time you receive this issue, we've already been to the ISHRS Annual Scientific Meeting in Amsterdam. Up to this point, it has been quite an adventure organizing the Surgical Assistants meeting. It's been a pleasure to meet and work with some of the most talented assistants dedicated to this field. I am very fortunate to have had these assistants and doctors volunteering their time to help make the Surgical Assistants program a success.

A special thanks to:

Dr. James A. Harris
Dr. Nilofer Farjo
Kathryn Lawson
Anne Wheeler
Louise Clarke
Julie Edwards
Laurie Gorham
Dr. Miguel Canales
Dr. Emina Karamonoski
Janna Shafer
Brandi Burgess
Marilynne Gillespie
Brenda Deacon
Claudia Moser
Dr. Mark Di Stefano
Veselina Jelisavac
Anne Knudsen
Marie Franck
Bonnie Minardi
Michelle Woodhouse

2009 Executive Committee:

Laurie Gorham
Ailene Russell
Emina Karamonvski
Cheryl Pomerantz
Marilyn Gillespie
Margaret Dieta
MaryAnn Parsley
Brandi Burgess

Last but not least, this conference would not be what it is without all the staff at ISHRS headquarters working countless hours putting this annual meeting together. Thank you to Victoria Ceh, Jule Uddfolk, Kimberly Miller, Liz Rice-Conboy, Katie Masini, and Jeff Miller for all your hard work! Victoria, I could not have done it without you!

The 18th ISHRS Annual Scientific Conference will be held in Boston, Massachusetts, October 20-24, 2010. Our Forum Editor, Laurie Gorham will be the new Chair for the Surgical Assistants Program. If you would like to be involved, please contact her at laurieg@bosley.com.

Thanks to all who came to Amsterdam. I hope you learned some pearls and met some wonderful people.

Thanks,
Tina Lardner Chair, ISHRS Surgical Assistants Executive Committee
Email: tlardner@aol.com • Phone: 877-694-9381

Surgical Assistants: Get Involved in the ISHRS...

We would love to hear from you. There are many ways you can contribute:

- Write an article or present an idea to the Forum
- Serve on the Surgical Assistants Executive Committee
- Help in the planning of our educational events
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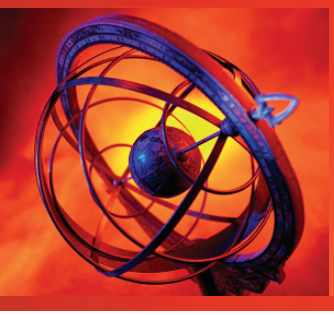

INTERNATIONAL SOCIETY OF ISHRS HAIR RESTORATION SURGERY

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 2009	International European Diploma for Hair Restoration Surgery	Coordinator : Y. CRASSAS. MD, University Claude Bernard of Lyon, Paris, Dijon (France), Torino (Italy), Barcelona (Spain). Department of Plastic Surgery *www.univ-lyon1.fr*	For instructions to make an inscription or for questions: Yves Crassas MD *yves.crassas@wanadoo.fr*
September 17–18, 2009	BAAPS Annual Meeting Incorporating the 2nd Congress of EASAPS *City Hall, Cardiff, United Kingdom*	British Association for Aesthetic Plastic Surgery (BAAPS) www.baaps-easaps.meeting.org.uk	Tel: + 44 207 430 1840; Fax: + 44 207 242 922
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 6–8, 2009	An Intense Hands-On Cadaver Workshop for Physicians & Surgical Assistants Hair Restoration Surgery *St. Louis, Missouri*	Practical Anatomy & Surgical Education, Saint Louis University School of Medicine In collaboration with ISHRS *http://pa.slu.edu*	Tel: 314-977-7400 Fax: 314-977-7345 *pa@slu.edu*
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*
December 12–13, 2009	15th Annual Scientific Meeting and Live Surgery Workshop *Kobe, Japan*	Japan Society of Clinical Hair Restoration *www.jschr.org* Hosted by Hiroto Terashi, MD	Tel: + 81-78-382-6251 Fax: + 81-78-382-6269 *terashi@med.kobe-uac.jp*
December 19–20, 2009	1st Annual Meeting of the Indian Association of Hair Restoration Surgeons *Ahmedabad, India*	Indian Association of Hair Restoration Surgeons *www.ahrsindia.com*	Dr. Tejinder Bhatti Secretary, Indian Association of Hair Restoration Surgeons Phone: + 91-9923215042 *dearbhatti@gmail.com*
May 20-22, 2010	XIII International Congress of ISHR *Capri, Italy*	Italian Society of Hair Restoration *http://www.congresso.ishr.it/*	*info@ishr.it0*

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

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