How I do it

Bertram Ng, MD *Hong Kong, China* Email: ngbertram@yahoo.com.hk

The running subcutaneous suture without knots

William M. Parsley, MD *Louisville, Kentucky* Email: parsley@bellsouth.net

For the last 16 months I have been using a running subcutaneous suture without knots exclusively and have found that my strip scars are considerably improved. This technique was first mentioned to me several years ago by Dr. Ed Epstein and, more recently, by Dr. Arthur Tykocinski (but with knots).

The Technique

1. Insert an absorbable suture about 5mm beyond the point of incision and then run it horizontally in the space between the bottom of the bulbs and the galea. Stay above the neurovascular plexi but avoid wandering superiorly and catching some hair follicles. I use 4-0 Biosyn but any braided absorbable suture should work equally well (Figure 1A).
2. Secure the end of the suture, if not using a knot, either with a hemostat or lead-free small fishing sinker. The latter is easy to clamp onto the suture (Figure 2A).
3. Take big subcutaneous bites up to a centimeter in size. Where the fat is too broken up or weak to hold a suture, take small bites of the galea being careful to avoid vessels (Figure 2B).
4. Avoid using the suture to pull the edges together during suturing. Tension clamps are used in advance of the suture to pull the skin edges together, and then on the already sutured section to pull the edges even closer together.
5. Upon reaching the end of the incision, run the suture back out of the skin about 5mm past the end of the incision and secure it with hemostat or another lead-free fishing sinker (Figure 2C).
6. Pull on the fishing sinker and cut the end of the suture at the skin level after closing the skin with a running suture (usually with a trichophytic closure). The suture will retract under the skin (Figure 1B, C, and D).

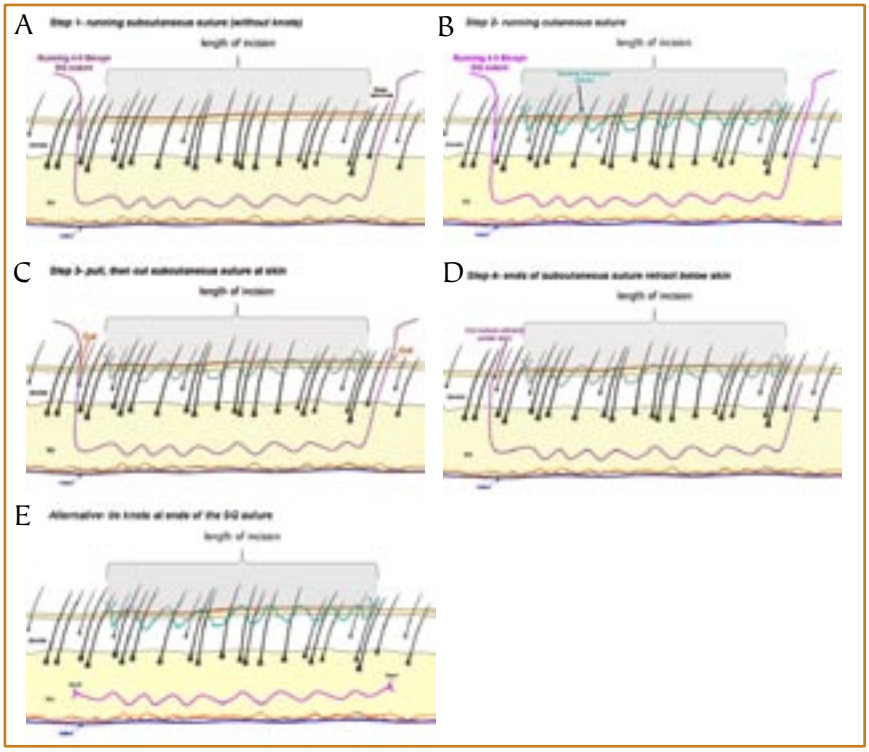

Figure 1. Diagrams of Procedure: These figures show diagrams of the steps in the running SQ closure, starting after the strip excision. A: The initial placement of the running horizontal SQ absorbable suture (not shown is securing its exit from the skin with sinkers or hemostats). B: The closure of the surface defect. C: Pulling up on the suture and clipping it at the skin junction. D: Retraction of the suture beneath the skin. E: An alternate method using SQ knots if knotless technique is not desired.

Some may be skeptical that fat will not hold the suture. I know of one surgeon who left a length of suture out of the skin at each end for a week and did not observe any pulling back into the skin, demonstrating that the suture could hold its tension even without tying a knot.

Practical Tips

- Use tensions clamps or your forceps to pull the SQ together rather placing much tension on your suture. The SQ will pull together but not the skin surface edges.
- The galea should not be visible before the skin surface closure. The follicles on the opposing walls should be parallel. The term "subcutaneous suture" has been used by many doctors to label what in reality are dermal sutures. In this technique it is truly "subcutaneous."
- Hemostats can get in the way and occasionally snap the suture. The use of lead-free clampable sinkers can avoid this problem and not affect the outcome.
- The important aspect is really the subcutaneous closure. The decision to "knot" or "not knot" the ends of the SQ suture is mainly a personal preference.

Theoretical Advantages

- It closes all of the dead spaces.
- It aligns the hair follicles better.
- It relieves much of the tension on the skin closure without damaging the follicular shafts.
- It creates no confined space as do interrupted dermal or subcutaneous sutures.

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- It leaves no buried knots that can spit or cause discomfort.

Is it the answer to all bad scars? Unfortunately, no. There are still some occasional slightly stretched scars but so far they seem to be less than my scars from my previous technique of combined dermal interrupted sutures/cutaneous running sutures.

Give it a chance. You may find that a higher percentage of your scars are difficult if not impossible to detect.✧

Figure 2. Operative Photos: A: Non-lead sinker clamped on the suture to secure edges. B: Closing of the SQ fatty layer. C: Use of tension clamps to get a closer approximation.

Hair's the Question "?"

Sara Wasserbauer, MD *Walnut Creek, California*

Editors' Note: This is the first submission of a new column that will help us check our knowledge about different hair disorders. Dr. Sara Wasserbauer, who will be in charge of this column, is a Diplomate of the American Board of Hair Restoration Surgery and an active member of the ISHRS. She practices hair restoration full-time at her office in the Bay Area, outside of San Francisco, in Walnut Creek, California. Dr. Wasserbauer earned her medical degree from the Medical College of Ohio. After finishing her training in Internal Medicine in Denver, Colorado, she completed her fellowship in hair transplantation (September 2004-September 2005) with Dr. Matt Leavitt in Orlando, Florida. The answers to these multiple choice questions will be found at the end of the column along with a brief explanatory note.

Diffuse Hair Loss

As hair surgeons, we are used to seeing all manner of pattern hair loss, but diffuse hair loss is a different animal altogether. Plus, since diffuse hair loss is less often a surgical problem, I find myself having to mentally switch gears whenever I am confronted with it. To that end, here is a little mental "brush-up" for those of you out there like me who like to quiz yourself. Good luck!

1. Diffuse hair loss should be considered abnormal in which of the following cases:
   a. In a young male patient who is shedding 100-150 hairs per day.
   b. Anagen hair loss.
   c. In anyone with a family history of Androgenetic Alopecia.
   d. Hyper- or Hypothyroidism.

2. Which of the following is NOT among the differential diagnoses for diffuse hair loss?
   a. Short anagen syndrome, loose anagen syndrome, or anagen effluvium.
   b. Alopecia areata, totalis, or universalis.
   c. Hair breakage due to chemical or genetic causes.
   d. Trichotillomania or traction alopecia.

3. In the differential diagnosis of diffuse hair loss, which is the most common?
   a. Loss of telogen phase hairs commonly identified clinically by the "nubbin" of the released bulb at the end of the shaft.
   b. Alopecia Universalis.
   c. Anagen phase hair loss most commonly resulting from radiation or chemotherapy.
   d. Early androgenetic alopecia presenting as episodic shedding.

4. Which of the following is the most common cause of diffuse hair loss?
   a. Hairs prematurely moving into telogen phase from anagen phase due to a variety of causes including diet, medical conditions, and emotional stress.
   b. Physiologic stress including severe and sudden weight loss, surgical trauma, high fever, parturition, loss of blood, and chronic illness.
   c. Drug treatment with beta-blockers, ACE inhibitors, antidepressants, OCP and hormone replacement therapy.
   d. Androgenetic alopecia.

5. Which of the following can cause diffuse hair loss?
   a. Diffuse hair loss starting 2 months after an illness with high fever and significant blood loss.
   b. Diffuse frontal (possibly pattern) hair loss, with a history of patchy loss and re-growth.
   c. Diffuse hair loss starting 2 months after beginning treatment with beta-blockers and anti-fungal medications.
   d. All of the above are correct.

6. Lab evaluation of diffuse hair loss in any patient should include:
   a. VDRL or RPR to rule out syphilis.
   b. CBC, Ferritin, TSH, T3/T4.
   c. Complete metabolic panel and total testosterone level.
   d. Serum Zinc, B-vitamin, and Biotin levels.

7. Diffuse anagen hair loss:
   a. Can be normal in some cases.
   b. Is only caused by radiation or chemotherapy.
   c. May require work-up for heavy metal poisoning.
   d. Is inconsistent with a diagnosis of alopecia areata.

8. A 35-year-old female patient complains of chronic diffuse hair loss, thin hair, and slow hair growth. She has had shedding and thinning hair since her teens. She is a strict Vegan vegetarian but takes no drugs, and has an otherwise unremarkable medical history. Labs are all normal. You feel comfortable telling her that:
   a. She likely needs to add more protein to her diet and come back for a follow-up in 6 months to 1 year.
   b. Iron, Zinc, B-vitamin, and Biotin supplements will help as will 5% Rogaine and daily Spironolactone.
   c. She is a candidate for either Propecia with daily Yasmin Oral Contraceptive Pills or hair transplant surgery.
   d. Any plan for hair transplant surgery should concentrate grafts on the top frontal area and should only move 1,200-1,800 grafts at a time to minimize shock loss.

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9. In evaluating a patient with diffuse hair loss, which of the following would be a reasonable initial step:
   a. Examining the hair for breakage and taking a history for chemical damage.
   b. Scalp biopsy.
   c. Lab tests.
   d. Questionnaire and targeted medical history for trichotillomania.

Answers

1. B. Anagen hair loss is never normal and is typically associated with radiation or chemotherapy. Diffuse hair loss can affect both sexes at any age and shedding 100-150 hairs per day is normal. Thyroid conditions, both hyper- and hypo-, can cause diffuse telogen hair loss. Even without a clear Savin or Norwood pattern classification on exam, episodic shedding can be an early presentation of androgenetic alopecia in both sexes.
2. D. Both trichotillomania and traction alopecia would result in focal hair loss. Hair breakage due to chemical or genetic causes can result in either focal or diffuse hair loss. The others all result in diffuse loss and would be considered in the differential diagnosis of diffuse hair loss.
3. A. Telogen effluvium is not a complete diagnosis by itself, but as a sign of an underlying condition (from whatever cause) it is the most common presentation of diffuse hair loss. In a hair transplant practice, the self-selection bias may lead one to choose D. Answer B, "Universalis," only sounds common.
4. D. Telogen effluvium is the most common cause of diffuse hair loss, although all of the above are correct and a hair surgeon is most likely to see a predominance of patients with androgenetic alopecia.
5. B. You would be suspicious for diffuse alopecia areata. The others are very likely to be telogen effluvium and would not require scalp biopsy unless you could not exclude areata or the hair loss was chronic.
6. B. You would add the others if the history and physical suggested risk factors for these specific conditions. Biotin is a useful supplement but many practitioners may simply choose to supplement empirically with B-vitamins or Zinc if they thought it would be helpful.
7. C. Anagen hair loss is never normal. Radiation treatments, chemotherapy, alopecia areata, and heavy metal poisoning can all cause anagen hair loss.
8. A. Vegan vegetarians or any patient on a very restricted diet are at risk for diffuse hair loss. Causes include low protein, iron, zinc, and fatty acid deficiency. Hopefully, off-label 5% Rogaine AND Spironolactone (an anti-androgen in a female not otherwise using contraceptives) made you feel a little uncomfortable choosing B. Hair transplant would not be the best initial option for this patient, especially without further work-up and trials of other treatments first. Propecia is inappropriate in a young female patient who is actively trying to conceive.
9. A. Scalp biopsy and lab tests should follow an initial history and physical exam. Trichotillomania is more likely to cause focal hair loss and so would not be appropriate as a first step to evaluate someone with diffuse hair loss.✧

Letters to the Editors

Konstantinos Giotis, *DHI Medical Group Athens, Greece*

Re: Hair Restoration Surgery Is Not the Airlines Industry

One of the most interesting sessions of the ISHRS meeting last month in Amsterdam was without a doubt the MEGA vs. GIGA session.

Both sides had some great arguments and it seems in the end the giga was the winner. The paradigm given that, sure, if you were going to FLY direct to a destination, it is much preferable to a three-stop flight, seemed to win the audience.

This simplification of the issue is dangerous...we all know the problems that mega sessions have created for our industry when an inexperienced team full of enthusiasm and greed perform such mega sessions.

Let's face it, how many teams in the world can produce consistently good results? We all know that mega sessions require large, well-trained teams and long hours.

Hair follicles are so complex yet so fragile, who can guarantee that all follicles will survive that long trip with many stops, handled by many assistants for so many hours?

And can we afford to waste even one hair follicle? Is this what our patients deserve?

First DO NO HARM was the Hippocratic declaration.

Now we have giga sessions for FUE—12,500 follicles in 6 hours proclaimed an email I received today by a clinic in Europe—I am very concerned with this race.

This is "MORE FOR LESS": More time, more discomfort for the patient, probably more scars, and sure more money. But, in my opinion, also more risk of less hairs to grow and more unhappy patients.

The study I presented at the ISHRS meeting will continue, and we have found a large number of patients are very unhappy with their hair restoration experiences. Over 2,000 from many countries participated in this study—which still continues. Seventy percent were disappointed with their previous treatments and 20% very disappointed. I am certain that number will rise if the other 10% knew that some of their hair follicles of their mega sessions had been destroyed forever.

So I am deeply concerned what will happen with giga sessions as many doctors and clinics will jump on this new era for hair restoration.

How many teams throughout the world today and in the next 2 years can perform 6,000 to 8,000 grafts or more giga sessions?

Hair restoration has made some great improvements in the last 10 years but it is far from reaching the safety levels of the Airline industry. In fact, we are much behind other cosmetic and plastic surgery procedures or other medical procedures in general. Till we reach that level of recognition and acceptance, I strongly propose "LESS IS MORE."

If THINK–FEEL–SAY–DO is the norm on most human activities, then FEEL–FEEL–FEEL–FEEL should be the priority for our industry.

This is the direction DHI Medical Group (www.dhiglobal.com) is heading, and we all should work together in common goal with specific protocol and guidelines.✧

Nilofer Farjo, MD *Manchester, United Kingdom*

Re: Inspection visit to Dr. Pathomvanich's Fellowship in Thailand

Visiting colleagues around the world is definitely a great learning experience not to mention the chance to see wonderful countries. On June 26, 2009, we had the pleasure of visiting Dr. Damkerng Pathomvanich at his clinic in Bangkok. Bangkok, Thailand, is a bustling city of over 10 million with exciting cultural attractions, plenty of modern facilities, a good public transport system, and great food! Don't drive anywhere though as the traffic moves at a snail's pace all day long. We took the opportunity to have a family holiday that was much enjoyed even with the 32°C/90°F weather.

Dr. Pathomvanich operating with his fellows Dr. Parvin Sadrolodabaei, general surgeon *(left)*, and Kulakarn Amonpattana plastic surgeon.

As part of the fellowship scheme, a fellowship director has to be inspected every 5 years to ensure that they are continuing to follow the guidelines set out by the ISHRS. As I am a member of the fellowship committee, I was asked to report on Dr. Pathomvanich's program. Currently he has 2 fellows with him. They both recently attended the Amsterdam meeting with one giving an oral presentation and the other a poster presentation.

Fellowship Training

The requirements of the training program are quite rigorous and include keeping case logs of training surgeries, a written training program that includes details of daily, weekly and monthly activities for the fellows, research projects, and journal articles. The clinic environment has to be inspected to ensure compliance with health and safety regulations including infection control. At least two surgical procedures are observed by the inspector and a number of patient notes are reviewed. Fellows are required to participate in planning, performing procedures, and aftercare; attend meetings; work on a research project; and present their findings.✧

Surgeon of the Month: Robert H. True, MD

Maurice Collins, FRCSI *Dublin, Ireland*


Dr. Robert H. True

If one wanted to illustrate the extraordinary level of surgical professional who is attracted to hair restoration, we could do no better than introduce Dr. Robert H. True. Hair restoration is a fast-growing discipline with an increasing public profile that requires high calibre surgical professionals to advance its theory and clinical practice. Robert, known as Bob, does both and is also an active researcher. He brings a wealth of experience and a rich medical background to the field. Based in New York, Bob is Diplomate of the American Board of Hair Restoration Surgery and a recognised authority on hair loss.

Bob did his undergraduate study at the University of Wyoming, which he followed with a Bachelor of Science from McGill University (Montreal, Canada). He received his medical degree from McGill University Faculty of Medicine and pursued postgraduate training at the University of Illinois, the Mayo Clinic, and John Hopkins. He also had a distinguished career as the Director of Emergency Medicine for St. Francis and as a decorated Clinical Director with the U.S. Public Health Service Commission Corps.

Bob was introduced to surgical hair restoration in 1991 by Dr. R.M. Elliott. Fascinated with the blend of artistry and detailed technique required, he was immediately drawn to the practice. He spent six months working daily with Dr. Elliott in a clinical preceptorship prior to beginning a full-time hair restoration practice in New York in 1992. He has performed more than 18,000 procedures and is proud to count among his patients men and women from many nations and occupations, as well as many well-known personalities.

Bob has presented at many major professional meetings in the U.S. and abroad and published in professional journals on a broad range of topics related to hair restoration. At the most recent ISHRS meeting in Amsterdam he presented a novel approach combining FUT and FUE in the same procedure. Among the first physicians to be certified by the American Board of Hair Restoration Surgery, he serves as an examiner and director for that body and will be the president of the ABHRS in 2010.

Bob is senior partner of the True & Dorin Medical Group P.C. His and Dr. Robert Dorin's private practice is located in Manhattan, with satellite offices throughout the northeastern United States, and is devoted solely to surgical hair restoration and medical therapy of hair loss. In addition to being partners, Bob True is also Dr. Dorin's mentor in hair restoration, a relationship that began when Dr. Dorin was Bob's patient while still in medical residency.

Born in 1947 in Cheyenne, Wyoming, Bob is the middle of three children of a highway engineer and horticulturist. Both parents were artistic and Bob believes they instilled in him his love of design and artistry. He was inspired to pursue medicine by his grandfather who was a general surgeon (the second to set up practice in the frontier town of Cheyenne).

Happily married for 35 years to Sandra, who recently retired from being the founding Director of the Nurse Family Partnership for the City of New York, they have two children. Their daughter Lynn is an independent documentary maker and their son Mark is a general surgeon in Anchorage, Alaska. They also have two grandchildren.

Bob and Sandra have worked extensively as volunteers with underserved communities around the world, starting with south side of Chicago and including India, Egypt, Jamaica, the Philippines and Marshall Islands, and South Korea. Their work in recent years has focused on the problem of HIV/AIDS and part of each year is spent in Africa—Kenya, Tanzania, Uganda and most recently, this summer, Malawi.

Bob is a keen amateur geologist and anthropologist who enjoys exploring the remote wilderness areas and ancient cultures of the American southwest. He is also an avid fly fisherman, gardener, yoga practitioner, and long-distance cyclist. On his 60th birthday he decided to take up running and has now run several half marathons and will run his first full marathon in New York later this year.

I asked Bob to describe why hair restoration is the specialism for him, he explains: "Well, I am by nature a contemplative, patient, and meticulous person. Knowing I have helped someone resolve an important concern in their life is more rewarding to me than any financial compensation. I enjoy the sense of accomplishment that comes from well-honed teamwork. And I thrive in an atmosphere of constant striving for perfection. In other words, hair restoration seems a match made in heaven for me."

Dr. Robert (Bob) True brings an impressive combination of experience, expertise, and wider interests to the field of hair restoration and, for that reason, he is our Surgeon of the Month.✧

ABHRS NEWS

The American Board of Hair Restoration Surgery has now been in existence over 11 years. Its 134 Diplomates hail from 15 countries. The January 2009 exam produced 10 new Diplomates from 5 countries. They are: Marc S. Dauer, MD (U.S.), James A. Harris, MD (U.S.), Jason Lukasewicz, DO (U.S.), Pekka J. Nyberg, MD (Switzerland), Angela L. Phipps, DO (U.S.), Pathuri Madhusudana Rao, MD (India), Ana Trius, MD (Spain), Robert A. Wadden, MD (Canada), William J. Woessner, MD (U.S.), William D. Yates, MD, FACS (U.S.).

Consistent with its strong commitment toward Maintenance of Certification (MOC), the ABHRS recertification exam was again administered both last January in Houston, along with the Certifying Examination, and in Amsterdam at the ISHRS Annual Meeting. Those who successfully completed their 10-year recertification exam this year were: Robert M. Bernstein, MD, Steven B. Hopping, MD, and Bradley R. Wolf, MD. (Results have not been determined for the Recertification Exam held on July 22, 2009, in Amsterdam.) The next Annual Certification Exam and Recertification Exams will be administered at the Houston International Marriott Hotel on Saturday, January 23, 2010.

We welcome Paul J. McAndrews, MD, as a new member to serve as an Officer and Treasurer on the Board of Directors for a 1-year term of office. The Treasurer would eventually ascend over the years to Secretary, Vice-President, and, ultimately, President. We commend our Immediate Pas t President, Bernard Nusbaum, MD, for his leadership and support and appreciate his valuable time. We also commend the following colleagues who have completed their first term of office on the Board of Directors and were re-elected to serve a second term of 3 years: Glenn M. Charles, DO, Bessam Farjo, MD, Robert J. Reese, DO, Robert H. True, Jr., MD, and Walter P. Unger, MD.

The current Officers are: Daniel W. Didocha, DO, President; Robert H. True, Jr., MD, Vice-President; Glenn M. Charles, DO, Secretary; Paul J. McAndrews, MD, Treasurer.

The other Directors not mentioned above are: Vance W. Elliott, MD, John D.N. Gillespie, MD, Sungjoo Tommy Hwang, MD, PhD, Russell Knudsen, MD, Bernard Nusbaum, MD, David Perez-Meza, MD, William H. Reed, MD, and Marla Ross, MD.

The ABHRS Board of Directors unanimously adopted a resolution designating the ISHRS CME Award as the necessary requirement for satisfying the CME component of the Maintenance of Certification program of the ABHRS. The application for the CME award can be obtained from the ISHRS website at ISHRS.org. In addition, for the purpose of consistency in adopting a uniform advertising policy, the Board of Directors adopted a provision stating that, as opposed to "Board Certified" or "Certified by," the only appropriate way for ABHRS members to advertise their certification status is as a "**Diplomate of** the American Board of Hair Restoration Surgery."

Classified Ads

Hair Techs Wanted

Must have at least one year of documentable experience and Reliability is a must.
Good pay for qualified, professional, independent techs.
Please submit resume to hairtechneeded@yahoo.com

Laser for Sale

Revage 670 laser for sale. Best cold laser for Hair Growth in the industry. Normally retails for 60k, less than 1 year old with just a few uses. Practice shutting down. Will sell for 35k OBO.
Call Danny at 949-689-9315 or e-mail danny@efficientlending.com

Seeking Hair Transplant Surgeon

Seeking physician to join me in established Hair Restoration practice in Miami, Florida
Contact Bernard Nusbaum, MD
drnusbaum@yahoo.com

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