Letters to the Editors

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

Re: Dr. Rassman's Article on Unethical Behavior

I was very happy that Dr. Rassman wrote "Areas of unethical behavior practiced today" in the *Forum* (September/October 2009; (19)5:149). During the 23 years I have specialized in this field, I have directly observed that while the majority of hair restoration surgeons are honest and compassionate, we still have a disappointing number whose ethics are unacceptable. These activities and practices unfairly reflect on our *entire* field. Dr. Rassman covers several points displaying bad behavior on the part of hair restoration surgeons in how they interact with their patients, which then is reflected into the public domain. Unfortunately, even during good economic times over the past two decades, these same practices have occurred.

Every day patients come into my office for consultations with information they received from colleagues that is *incredulous*. Recommendations of *thousands* of grafts in a young man with *early* thinning in the central frontal area, transplantation or scalp reductions of a *young* man's crown, or transplantation in patients with diffuse hair loss (including in the entire donor region) are just a few. They are recommendations for purposes of greed and not for the patient's best interest…and, it's nothing new. Additionally, patients are coming in with stories of very large transplant sessions for very, very little money.

Something that happened just three weeks ago is that I have been hearing ads on the radio indicating a "full head of hair for $7,500" and "32 years of experience". It was paid for by a family physician that was recruited by a hair transplant technician who had worked for a number of doctors over a 15-year period of time. She contacted me a couple of years ago wanting to open a hair transplant clinic in a nearby community and wanted me to do the surgeries. I respectfully declined her offer. This doctor apparently decided to go into a business arrangement with her.

I have worked very hard in my practice community *as has the ISHRS nationally and internationally* to provide the general public with good information and knowledge as well as realistic expectations about hair transplantation, so I called the doctor in the spirit of open communication and concern about this issue.

As a veteran in this field, I was hoping to help this newcomer to understand that the field of hair restoration surgery had had a significant negative public image for decades in the past, not only because of archaic techniques, but because of communication by those in the field of unrealistic expectations (over and under selling… and worse). Though I sincerely called him in the spirit of trying to help him as well as to help to protect our field, he didn't take my call in that manner. Because I had never met him at any meeting, during our conversation I asked him where he learned to perform hair transplant surgery. He told me that he *"didn't have to go over his resume with me"!*

He obviously did not take my call in the spirit it was made. It truly is unfortunate because all I was attempting to do was to preserve our profession's increasingly positive image by the public and to help him when these patients come back to him not having the "full head of hair" he told them they would have.

Whether you are old or new in our field, please take a look at how you are presenting information to your patients and to the public. If what you see is not proper—and you know in your heart that it just is not right—then change! Take the high road for yourself, for your patients, for the public, and for our profession.✧

Walter Unger, MD ***New York, New York***

Re: Dr. Rassman's Article on Unethical Behavior

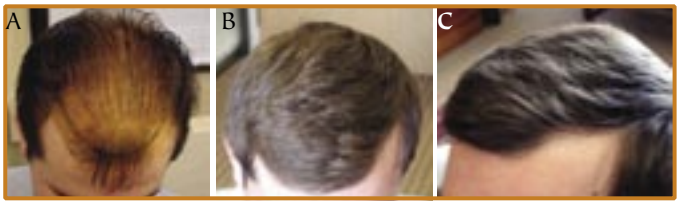
At the outset I should make clear that in my career of over 40 years and somewhere between 5,000 and 10,000 patients, I have probably operated on fewer than five young men aged 21 years or less. I think we can all agree that because there is no way of being certain of the eventual severity of MPB (incidentally at *any* patient's age) that the younger the patient, the more reluctant the physician should be about carrying out hair restoration surgery. It is, however, in my opinion, a huge jump from that generality to Dr. Rassman's absolute statement that "performing surgery on very young men (18-22 years) with early miniaturization is, in my opinion, outside the Standard of Care" (Areas of unethical behavior practiced today, *Hair Transplant Forum Int'l.,* 2009; (19)5:149).

Such a position ignores many variables including the severity of the patient's emotional trauma, the extent of any family history of Male Pattern Baldness (MPB), his ability and that of his family to truly understand and accept the potential disadvantages of early hair transplanting (which of course should be completely discussed with them), their willingness to delay surgery whether to try medical treatment first or to reconsider any strong preference to *not* try medical treatment (for a variety of reasons), their time and financial resources, and other factors. Because of the variables, the sometimes incredibly difficult questions of whether or not there should be a minimum age below which hair restoration surgery should not be carried out, and what that age should be, have been heatedly debated upon by many hair restoration surgeons whose experience, skills, and ethical qualifications are as credible as those of Dr. Rassman. He is aware of that reality so it surprised me that he would have used a phrase so inherently pregnant with medico-legal implications: *"standard of care"*. He was careful to state that this was his opinion, and I therefore felt that the least I could do was to document my contrary opinion. Similarly, I do not believe that one year of compulsory medical treatment should be "the Standard of Care" before surgery is undertaken. A case history is worthwhile to use an example of why I take those positions:

A 19-year-old I operated on 3½ years ago was brought to me by his grandmother who told me he had dropped from the top of his class to near the bottom, stopped smiling or going out with friends, always looked depressed and who had confessed to her his deep depression because of rapidly advancing and severe hair loss in his frontal and, to a lesser extent, midscalp areas (see photos). He came from an extraordinarily wealthy family so money was absolutely of no concern. There was no family history of Type VII MPB. Given all of the preceding factors, I thought early surgery, rather than medication was a better choice for his treatment but discussed the medical options with them. Why was that my opinion? I knew that in this patient, with a dense and wide donor area, surgery would rapidly produce an excellent outcome in the frontal area and in his emotional state. On the other hand, both finasteride and minoxidil have never even

been properly studied in that area so we only have anecdotal information that they are effective to a variable extent in a minority of patients and rarely, if ever, as effective as the hair transplanting results I and other skilled hair restoration surgeons see in our practices. Furthermore, even if they were effective, they would have to be continued forever or the gains would be rapidly lost, and even if they were continued forever, their effectiveness would decrease with time (Unger, W., and R. Shapiro. Editor's Comments on Effect of Medical Therapy on Surgical Planning. Hair Transplantation, 4th edition. 2004. Marcel Dekker, 148-151). Given the preceding, why should/would a one-year course of medication be the "Standard of Care" for this particular young man's frontal area? (For MPB in the vertex area I would have insisted on one year's trial of medical therapy.) Six months after the frontal surgery he was started on Propecia® for his midscalp area and prophylactically for his vertex area. (I didn't want to confuse the response to the frontal transplant with any response to finasteride in the same area so I didn't start the latter until this point.)

One year after his frontal transplant, the patient was so thrilled with the results that he had decided not to wait another 6 months to assess the results of the finasteride for his midscalp. "I'll have to do it someday so why not sooner than later" was his reasoning. (Common in my practice.) I felt he had at least 3 more sessions available in his donor area and we were talking about only one of them—leaving me a "margin of error" of two sessions in the prognosis—so we proceeded with the second (photos B and C). This young man's life was transformed within six months of his first surgery but the emotional transformation began even sooner. He is now happily married and he and his wife recently had a child. He has thanked me profusely verbally, and in writing several times, the last time shortly after the baby was delivered, to tell me that he believed neither his marriage nor his baby would have happened if I hadn't "helped him." (Thirteen years ago I operated on a suicidal 16-year-old. A brief discussion of the circumstances can be found on page 131 of the 4th edition of Hair Transplantation. He is still content and not sorry he had the transplant.)



The subject of "miniaturization" that is not clinically noticeable except with magnification of the scalp in multiple areas deserves a fuller discussion than I can go into here. Suffice to say, however, that we know that MPB occurs in waves separated by intervals of stability that can last many years. Each period of loss is sometimes accompanied by, and always followed for a short while by, a higher percentage of "miniaturized hairs," some of which are in reality short, fine, early anagen hairs that are not being miniaturized by the MPB process *or* are only in the earliest of the many hair loss regrowth cycles that occur before total alopecia occurs. Such early anagen hairs *are clinically indistinguishable* from hairs that are actually miniaturized secondary to MPB. Furthermore, no study has ever been done that might indicate that a one-time examination with magnification that reveals higher than normal percentages of "miniaturized hairs" (never mind several such examinations at intervals) has any predictive value for how soon the next wave of loss will occur, how rapidly the MPB will evolve, or how severe the ultimate extent of MPB will be.

In brief, I believe that "miniaturization" that is only noticed with magnification, and that may or may not be due to MPB, appears to tell you something about the consequences of past as well as sometimes the current wave of hair loss, but there is no real evidence that it shows you anything about the rapidity and severity of evolving MPB. The exception to taking that position is a young man who already has *clinically* sparse hair in his donor area, or who on gross physical examination is already felt to be imminently destined to be in that state. Needless to say, a family history of early onset or severe MPB should be factored into that assessment.

Finally, this is not an argument in favour of the surgical treatment of MPB for the average young man age 21 or less or by the average hair restoration surgeon and team. Experience, judgment, and surgical-team skill all play a role in whether or not it is reasonable for any particular surgeon or patient to undertake a hair transplant. The courts will and should deal with those physicians who are too aggressive. What I believe, however, is that the courts do not need and should not be armed with a "Standard of Care" on a cosmetic matter that can be as complex as early hair transplanting, and that will "tie the hands" of ethical practitioners.✧

Mark S. DiStefano, MD *Worcester, Massachusetts*
Re: Dr. Rassman's Article on Unethical Behavior

It was shocking and disappointing to see as the lead article, in our own journal of the ISHRS, "Areas of unethical behavior practiced today," by Dr. William Rassman (September/October 2009; (19)5:149). I thought that we were trying to have a newsletter in which we try to "facilitate the free exchange of information, a less stringent standard is employed to evaluate the scientific accuracy of the letters and articles published in the *Forum*," quoted from the inside cover of the *Forum*.

First of all Dr. Rassman's article is an editorial, not a scientific letter or scientific article. Secondly, where are the facts in his editorial to substantiate his claim? Thirdly, did the editors view this as an article, did they actually evaluate the article for accuracy? I certainly believe they did not. It is neither a scientific letter nor a scientific article, how could they let it go to print if they actually evaluated it for accuracy. There are NO facts to evaluate. It is all anecdotal. In fact there was no study, no survey or any other scientific means used to allow Dr. Rassman to come to his conclusions. I certainly understand that this is what he believes based on his experience, but it does not reflect the general view of our organization as a whole.

Then, with this article lacking any scientific evidence, it was placed on the front page, as the lead article of our own newsletter.

Why would we do this? It does not make any sense to me. I understand this as an editorial piece, but certainly not as the lead article, which many individuals looking at our organization from the outside, would conclude that unethical practices are running rampant amongst us.

If Dr. Rassman had conducted some scientific survey with hard evidence, then this would make it worthy to publish, although certainly not in our best interest. What could Dr. Rassman hope to gain from this piece? Was this

➪ page 214

Letters to the Editors

from page 213

piece going to help solve these perceived problems? I do not think so.

Dr. Rassman is certainly one of the most outspoken members of our group. He has done much to promote our service, our product and our Society. And so with this piece, I want to believe that he wants us all to ponder what we do and how we do it, in these hard economic times. He suggests that "some of us" lower our standards to allow us to make ends meet. I am sure that there are some in our field who have chosen to operate sooner than we may have when things were busy. Maybe I, too, may not be as quick to dismiss a patient that I might have held off for a few more months when times were better. Maybe....

But I do know that most all of us do an excellent job working with patients and making them happy. In recent times, I have taken on tougher cases, ones that I otherwise would not have taken on in the past. This has pushed me to be better and work harder. I am sure other physicians have done the same. Maybe Dr. Rassman views this approach as either too aggressive or just not ethical. But remember when Dr. Rassman and others had been criticized in the past for their novel approach to the patient, time has shown that those methods were appropriate.

Again, I do not mind that Dr. Rassman makes unsupported claims that will absolutely hurt our profession, what I mind is that our newsletter, that represents our interests, not only uses this unscientific article as the current state of our profession but places it on the front page of our newsletter for the whole world to see.✧

A note from your editors, Drs. Jimenez and Nusbaum:

"Non-scientific" articles have been placed on the front page of the *Forum* in the past. In a quick review of past *Forum* issues since 2000, we found a great diversity of front-page articles. These include: song lyrics ("The follicular eunuchs," January 2000), personal opinions to conflicting topics ("Shame/Shame/Shame" by Dr. Martin Unger, November 2000), greetings to Meeting Chairs ("Kudos to Drs. Avram and Sandoval," November 2001), invited editorials ("Brave New World" by Gerard Seery, January 2002), opinion articles that reflect personal experiences ("Whatever happened to lasers?" March 2003), a variety of reports on meetings (May 2004, November 2006, May 2007), ISHRS News (ACCME accreditation, May 2006), emotive farewells (David Seager, Jim Arnold, and Blu Stough, January 2007, December 2007, and November 2008, respectively), invited editorials (Ralf Paus, May 2008), and so on. The former are just a few examples of leading front-page *Forum* articles from previous years. Moreover, if we strictly adhere to the criteria used to deem an article as "scientific" (evidence based objective data, etc.), roughly 40-50% of the *Forum*'s front-page articles would not fulfill these standards. The inside cover that Dr. Di Stefano quotes also states that the newsletter "was designed… as a forum to exchange thoughts, experiences, opinions…on all matters relating to hair restoration."

If numerous non-scientific articles have been on the front page in the past, why shouldn't we have considered Dr. Rassman's article for the front page? This was our decision as editors. Any decision, regarding any matter in life, can be argued and will have followers and detractors. Dr. Rassman clearly states that this is an "opinion piece," and it is our position that the issues raised deserve attention and that policing ourselves and discussing these matters with transparency reflects positively on our profession as a whole.

As editors, we felt that we would only do a disservice to our members by assuming a defensive posture and sweeping the article to the back of the issue.

Dr. Rassman's point was not to state that unethical practices are the "current state of our profession," but to note that while these practices involve a small number of physicians they have increased with the recent downturn in the economy. Moreover, he emphasizes that our responsibility ultimately is to the patient, so that if we are confronted by such a situation as he describes, we should not remain silent or feel obliged to protect the perpetrator.

IN REPLY

William Rassman, MD *Los Angeles, California*

Re: Response to Dr. Unger

"Above all, do no harm." This is a challenging statement for those of us in the hair transplant industry for if we transplant a normal man with no hair loss, have we really produced harm? Clearly the word "harm" is different for those who perform a relatively benign hair transplant than those who perform (on the other extreme) a life threatening invasive activity. So we are talking about the definition of the term "harm" in regards to hair transplantation. Harm to me means performing a hair transplant when the indications are not clearly present. The focus of my original article was upon the predatory behavior of some of our colleagues who try to make money by victimizing patients in the (1) improper or unnecessary delivery of hair transplants, (2) the timing and the extent of the transplant procedures performed, and (3) the competence of the physician and his team in performing them.

I subscribe to a concept that our responsibility in managing hair loss for our patients requires for us to have a Master Plan clearly in mind as we recommend treatment for hair loss, which is an inevitably progressive process. The progressive nature is more rapid in the very young patient and, although slowed with drugs like finasteride, the process is progressive nevertheless. Our ability to create a valid Master Plan in most 18-year-olds is limited. How do we manage an 18-year-old with early frontal (Norwood Class 3a) balding? Do we differentiate between those who are psychologically more impacted by the balding process than those who are not? Do we accelerate the surgical treatment before drugs like finasteride have been given a reasonable chance to stabilize or reverse the process? Where do we cut off the line between medical and surgical treatment based upon age? What if this same 3a patient is 18, 28, 38, or 58?

There is a real difference between a 3a pattern 18-year-old (unrelated to psychological state of mind) and the 28-year-old presenting the same way. The difference can usually be seen by mapping the scalp for the appearance of miniaturization by region. The 18-year-old will often have no significant miniaturization behind the frontal area making it a poor prognostic tool, while the 28-year-old will often show signs of miniaturization in the areas that will eventually become involved in the balding process. Patients with hair loss that begins before the age of 20 are much more

likely to have significant hair loss in the future, i.e., eventuate to be an advanced Norwood Class 6 or Norwood 7. In addition, their donor density is likely to decrease over time, and the donor reserves diminish. Transplanting them may make them better for the short term, but freakish looking in the long term. In many cases the scar from strip surgery will almost certainly prevent them from the optional short hair style used by many a balding young man today.

Making out a Master Plan for these two patient examples is far easier in the 28-year-old than the 18-year-old. I strongly feel that performing surgery on an 18-year-old without a reasonable trial of finasteride and psychological counseling is doing a disservice because one may not be able to build a realistic Master Plan for this 18-year-old. There is no doubt that we can build a density comparable to the original density to satisfy the 18-year-old's immediate needs, but restoring the 3a density to near normal levels may deplete 40% or more of his total hair supply. The psychological component is even more of a black box when a person is young and the impact of having a permanent donor scar and never being able to cut one's hair short cannot be ascertained when one is this age.

Dr. Unger's comments that he performed surgery in "fewer than five young men aged 21 years or less" in his 40-year career shows that he recognizes that these young patients are outliers and as such reflect a commonality of thinking about a "Standard of Care." But we both need to be clear that surgery in these very young men creates an exceptional situation for many of the reasons I discussed above. Waiting a year while the drug finasteride is tried gives the patient and his family time to consider the surgical option and we have all seen the occasional young man completely reverse his hair loss (including the frontal areas) during a 1-2 year course of drug treatment. Pre-emptive surgery will close the door on this opportunity. The hair transplant field is in desperate need of Standards because too many of our colleagues already jump on the hair transplant bandwagon for their own personal financial advantage. The easiest victims are very young men and far too many desperate women (another editorial yet to be written).

We are not in a stagnant field. Advances in drugs and cloning are on the horizon, maybe 10-15 years away, maybe more, maybe less. Different options will be available but the hair transplant done today on the 18-year-old will almost certainly limit his options in the future. We all know the impossibility in trying to undo the hair transplant process.

As the courts inevitably deal with the predatory physicians I originally discussed, these thoughts may give the courts some guidelines to work from. By taking a stand against those of us who are far too aggressive, I believe that this effort will serve to protect the consumer (the patient) more than it will to tie the doctor's hands. It will force doctors into ethical decision making—since some apparently don't do it on their own. The unethical doctor who often has a self-serving financial motive may be in conflict with the patient's best interests. He or she needs to be held accountable and it was to this end that I wrote my original article in the last edition of the *Forum*.

I would suggest reading the book "Blind Eye: The Terrifying Story of a Doctor Who Got Away with Murder" as it will reinforce our responsibilities to be vigilant and responsible on all issues of patient welfare.✧

Advances in Hair Restoration: Revolutionary Concepts and Evolutionary Techniques

Revolution & Evolution

SEAPORT HOTEL & WORLD TRADE CENTER

BOSTON ☆ 2010

MASSACHUSETTS USA OCTOBER 20-24

18TH ANNUAL SCIENTIFIC MEETING

Plan to Attend!

The ISHRS's annual scientific meeting is THE premiere meeting of hair transplant surgeons and their staff. You don't want to miss it.

There are many exciting formats and topics being planned for the 18th Annual Scientific Meeting, including a **Live Surgery Observational Workshop** aimed at beginners in the field, a full day, hands-on **Basics Course** in Hair Restoration Surgery utilizing cadaver scalp, a full day **Board Review Course**, a full day **Surgical Assistants Program**, several **morning workshop** on specific topics, a Surgical Assistant **Cutting/Placing Workshop** utilizing cadaver scalp, **lunch symposiums**, **"breakfast with the experts"** table discussion groups, **Live Patient Viewing**, several **controversy panels**, a **high definition surgical video theater**, a **hairline design panel**, use of an **audience response system** to keep the sessions exciting and dynamic, a full **exhibits** program, and many opportunities for **socializing and networking**.

Newcomers Are Welcome! As a result of the positive feedback from the 2009 annual meeting, we will again offer a "Meeting Newcomers Program" to orient those who are new to the ISHRS annual meeting. Newcomers will be paired with hosts. We want to welcome you, introduce you to other colleagues, and be sure you get the most out of this meeting.

Submit An Abstract A variety of abstract will be considered. Choose from four distinct types of abstracts:

1. Scientific study abstract
2. Abstract on a position or controversy *(e.g., How do you feel about body hair transplants? Dense packing? FUE? Trichophytic closure?)*
3. Abstract for a high definition video for the Video Surgical Theater
4. Abstract for a Live Patient Viewing Case

TO SUBMIT AN ABSTRACT GO TO:
www.ISHRS.org/18thAnnualMeeting.html
and click on **Submit an Abstract** to get started
SUBMISSION DEADLINE: FEBRUARY 15, 2010

2010 ANNUAL SCIENTIFIC MEETING COMMITTEE

Paul J. McAndrews, MD, Chair
Robert P. Niedbalski, DO, Basics Course Chair
Ricardo Mejia, MD, Basics Course Co-Chair
Sungjoo Tommy Hwang, MD, PhD, Board Review Course Chair
Glenn M. Charles, DO, Board Review Course Co-Chair
Ivan S. Cohen, MD, Workshops Chair
Mark S. Di Stefano, MD, Live Patient Viewing Chair
Nicole E. Rogers, MD
Ken J. Washenik, MD, PhD, Immediate Past-Chair
Laureen Gorham, RN, Surgical Assistants Chair

International Society of Hair Restoration Surgery
303 West State Street
Geneva, IL 60134, USA
Tel: 630-262-5399 or 800-444-2737
Fax: 630-262-1520
info@ishrs.org ★ www.ISHRS.org

Details and additional information about the meeting can be found at: www.ISHRS.org/18thAnnualMeeting.html

Surgical Assistants Editor's Message

Laurie Gorham, RN *Boston, Massachusetts*

Hello Fellow Surgical Assistants!

It's a pleasure and a privilege to be the chair of the assistant's meeting next October in Boston—my home town! If you attended the Amsterdam meeting I know you will agree that Tina Lardner did a phenomenal job and I know I have a tough act to follow! I have many ideas spinning around in my head and as the months pass I'll be contacting you all for suggestions and anything that you feel should be part of our meeting. As we say in Boston…if you would like to be "paht" of the program next "Octobah" please contact me at laurieg@bosley.com!

Laurie Gorham, RN

Editor, Surgical Assistant's Corner; Surgical Assistants Program Chair

Making your own training "Gel Scalp"

Laurie Gorham, RN *Boston, Massachusetts*

As I was clicking through cable television one night I came upon a show that was using ballistics gel to explore how a bullet passed through a body and what happened to it when it did. It was explained that Ballistics Gel closely simulates the density and viscosity of human tissue. So that got me to thinking. If I could get a scalp-shaped piece of Ballistics Gel, I might have something that would help in the training of our assistants! It didn't take long to type Ballistics Gel into my search engine and not only did I find that one could buy this, but even better—I could make it myself. So with my husband watching from his armchair, I went to work in my kitchen mixing a batch of Ballistics Gel in various ice cube trays and bowls, experimenting with molds and pie plates to find the perfect thickness for my "Gel Scalp."

Once I had a Gel Scalp created (see recipe), I realized that I also needed training grafts to place in the gel. I tried a tube of bath adhesive, some old suture, and a silicone board. This worked like a charm and I was able to trim out small "training grafts" that held up to placing in the Gel Scalp. These training grafts are, of course, not like the real thing, but they are certainly great as the first step in the training process. We are accustomed to using sharp instruments on a daily basis and my biggest worry in the early stages of training is sharps and blade injuries. The training grafts are a great tool to have for those first few times at the trimming station. Using silicone grafts to demonstrate how to hold the instruments and how to cut the grafts is a great way to keep injuries to a minimum. New technicians can become comfortable with the instruments without the worry that they will harm tissue or themselves in the process.

The Gel Scalp is sturdy but not perfect when making sites. It's hard to see the slit in the gel. The training grafts are firm enough that they can make the site as they are being slipped into the gel. This allows the trainer to instruct the new technician how to hold the instrument, how to angle the forceps in the correct orientation, and how to place the graft gently. I've been exposing new technicians to this tool for the past several months and have had positive responses. We will continue to develop training protocols with the Gel Scalp and training grafts, and we'll keep you posted on our progress.✧

Recipe for Training Gel

4 packages of unflavored Gelatin (one box has 4)
1 1/4 cups of tap water
1 small bowl
1 large bowl
1 9 inch pie plate
Non-stick cooking spray

Empty 4 envelops into the small bowl. Add 1 ¼ cups of hot tap water slowly avoiding bubbles. Dissolve.

Refrigerate for 2 hours.

Remove from refrigerator and float in a large bowl with hot tap water. The gel will dissolve. Allow to dissolve completely. This may take a few minutes.

Spray the pie plate with non-stick cooking spray.

Pour the dissolved gel gently into the pie plate. Refrigerate for a minimum of 12 hours.

Unmold the "Gel Scalp" and place on a wig head.

Silicone Training Graft Production

1 Tube of clear bathroom adhesive
Carpet thread or suture cut to 2-3cm pieces
Trimming boards and angled forceps

Squeeze a 1cm-thick line of adhesive on the board.
Slide the suture/threads into the side of the adhesive.
Allow to dry for 24 hours (Figure 1).
"Cut" into "grafts" (Figure 2).

Figure 1. The thread is slid into a 1cm-thick line of adhesive.

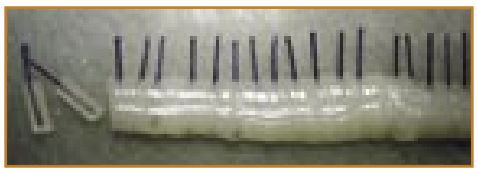


Figure 2. The threads are cut into "grafts."

Classified Ads

To Place a Classified Ad

To place a Classified Ad in the *Forum*, simply e-mail cduckler@yahoo.com. In your e-mail, please include the text of what you'd like your ad to read—include both a heading, such as "Tech Wanted," and the specifics of the ad, such as what you offer, the qualities you're looking for, and how to respond to you. In addition, please include your billing address.

Classified Ads cost $60 *plus* 60 cents per word per insertion. You will be invoiced for each issue your ad runs.

ADVANCING THE INDUSTRY OF HAIR RESTORATION.

OLSW

16TH ANNUAL ORLANDO LIVE SURGERY WORKSHOP

April 7-10, 2010, Orlando, FL

16

PRELIMINARY PROGRAM

Cadaver Workshop Available Daily

Special Surgical Techniques
- Eyebrow and Eyelash Transplantation
- Performing 2000+ Grafts with Efficiency and Comfort for the Patient
- Temple Points
- Numerous Cutting Techniques & Implantation
- Natural Hairline Design Workshop
- FUE – How to Perform Efficiently
- Trichophytic Closures
- Coronal Incision Transplant

New Instruments/Techniques
- Punch Machine / FUE
- Special Emphasis on Dense Packing
- Newest Implantation Instrumentation
- Dissecting Microscope
- Slot Correction for Scalp Reduction
- Laser Techniques, Newest Lasers

Research Symposium
- Genetic Research
- Hairloss Medical Review
- Dense Packing: Sagittal vs. Coronal Sites
- Growth Factors in Hair Restoration
- Follicular Unit Extraction vs. Follicular Unit Transplantation
- Graft Storage Solutions
- Laser Therapy in Hair Growth and Wound Healing
- Genetics of Hair Loss

Special Nurses Workshop Mentor Program
- Hands-on Practical Training
- Unique Cutting/Placing

Practice Management
- The Surgical Team & Selecting Staff
- Managing the Surgical Flow
- Designing the Perfect Facility
- Complications
- Marketing – how leaders build a practice
- Risk Management

LEARNER OBJECTIVES

Upon Completion of the Program, participants will:
- Understand the basic concept of hair restoration and apply this knowledge in practice.
- Understand the development of the latest techniques in hair restoration surgery and when they are best utilized for the patient.
- Evaluate the efficacy of hair loss medications and how to effectively use them in conjunction with surgery.
- Learn the various forms of alopecia, diagnosis techniques and the best approach to relevant treatments both medical and surgical.
- Comprehend the current data in genetic and medical research and its impact on hair restoration and patient care.
- Understand the various surgical techniques and their appropriate use with emphasis on follicular units, follicular extraction, scalp reductions, extenders, etc.

PROGRAM COORDINATORS & INVITED STAFF

Program Coordinators
Matt L. Leavitt, D.O., Chairman and Live Surgery Workshop Founder
David Perez-Meza, M.D., Co-Chairman
Marco Barusco, M.D., Program Coordinator

Past Invited Faculty
Patrick Frechet, M.D., Live Surgery Workshop Founder
Marcelo Gandelman, M.D., Live Surgery Workshop Founder
William M. Parsley, M.D., Scientific Coordinator
Melvin L. Mayer, M.D., Scientific Coordinator
E. Antonio Mangubat, M.D.
Mario Marzola, M.B.B.S.
Robert S. Haber, M.D.
Bobby L. Limmer, M.D.
Sheldon S. Kabaker, M.D.
Michael L. Beehner, M.D.
Martin G. Unger, M.D.
Russell Knudsen, M.B.B.S.
Dow B. Stough, M.D.
Robert T. Leonard, Jr., D.O.
Arturo Sandoval-Camarena, M.D.
Paul T. Rose, M.D.
Arturo Tykocinski, M.D.
Robert V. Cattani, M.D.
Marc R. Avram, M.D.
Ronald Shapiro, M.D.
Jung Chul Kim, M.D.
Rolf Nordstrom, M.D.
Glenn M. Charles, D.O.
Sharon A. Keene, M.D.
John Gillespie, M.D.
Mark Distefano, M.D.
Francisco Jimenez, M.D.
Bernie Cohen, M.D.
William H. Reed, II, M.D.
Damkerng Pathomvanich, M.D.
Jerry E. Cooley, M.D.
Alan J. Bauman, M.D.
Pierre Bouhanna, M.D.
Alex Ginzburg, M.D.
Paul M. Straub, M.D.
Shelly A. Friedman, D.O.
Carlos J. Puig, D.O.
Jerzy Kolasinski, M.D., Ph.D.
Richard C. Shiell, M.B.B.S.
Paul J. McAndrews, M.D.
Edwin S. Epstein, M.D.
Ivan S. Cohen, M.D.
Yves G. Crassas, M.D.
Ramon Vila-Rovira, M.D.
Mohammad H. Mohamand, M.D.
Ken Washenik, M.D. Ph.D.
Edwin Suddleson, M.D.
Vance Elliott, M.D.
Valerie Callender, M.D.
James Harris, M.D.
Antonio Ruston, M.D.
Bessam Farjo, M.D.
Art Katona, M.D.
Nilofer Farjo, M.D.
Bernard Nusbaum, M.D.
Robert Niedbalski, D.O.
Ricardo Mejia, M.D.
Vincenzo Gambino, M.D.
Sungjoo Hwang, M.D., PhD
Jennifer Martinick, M.B.B.S.
Paul Cotterill, M.D.
Craig Ziering, D.O.

Workshop Director
Valarie Montalbano

SPONSORED BY: THE INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY
REGIONAL WORKSHOP HOSTED BY: MATT L. LEAVITT, DO

Continuing Medical Education (CME) Credit - The International Society of Hair Restoration Surgery is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The International Society of Hair Restoration Surgery designates this educational activity for a maximum of 33.0 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity. The International Society of Hair Restoration Surgery's 16th Annual Live Surgery Workshop (program #1116-100) is recognized by the American Academy of Dermatology for 33.0 hours of AAD Category I CME credit and may be used toward the American Academy of Dermatology's Continuing Medical Education Award.

Dr. Matt L. Leavitt, D.O.

ADVANCE REGISTRATION—LIMITED ENROLLMENT—REGISTER NOW TO RESERVE YOUR SPACE

❑ Please enroll me in the Live Surgery Workshop. Course fee: $2075 ISHRS members; $2375 non-members; $875 training assistants. All major credit cards accepted.

Name & Specialty _____

Street Address _____

City _____ State _____ Zip _____ phone _____ Fax _____

email _____ credit card # _____ exp. date _____

Mail Registration to: Valarie Montalbano, Lake Faith Surgery Center, 260 Lookout Place, Suite #103, Maitland, FL 32751. No refunds 3 weeks prior to workshop. Workshop and hotel information to be sent upon receipt of registration fee. For additional information, contact: Valarie Montalbano Phone: (407)373-0700 Fax: (407)333-2140; E-Mail: HValarieM@leavittmgt.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 2009–2010 *Registration before Nov. 10, 2009*	Diploma of Scalp Pathology & Surgery U.F.R. de Stomatologie et de Chirurgie Maxillo-faciale; *Paris, France*	Coordinator: Pr. P. Goudot Directors: P. Bouhanna, MD, and M. Divaris, MD	Tel: 33 + (0)1 + 42 16 13 09 Fax: 33 + (0) 1 45 86 20 44 *sylvie.gaillard@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*
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*
March 12-13, 2010	ISHRS Regional Workshop Cowgirl Hair Loss Workshop *Katy, Texas, USA*	International Society of Hair Restoration Surgery *www.cowgirlhairloss.com* Hosted by Carlos J. Puig, DO	Tel: 281-347-4247 *cpuig@HairDocTexas.com*
April 7–10, 2010	ISHRS Regional Workshop 16th 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 ext. 103 *HValarieM@leavittmgt.com*
April 14-17, 2010	Hair Restoration, Alpine Workshop *Le Chabichou Hotel* *Courchevel, France*	University Claude Bernard Lyon I , European Graduate Hair Diploma Society	Yves Crassas, MD *yves.crassas@wanadoo.fr*
May 20-22, 2010	XIII International Congress of ISHR *Capri, Italy*	Italian Society of Hair Restoration *www.congresso.ishr.it/*	*info@ishr.it*
June 25-27, 2010	ISHRS Regional Workshop New Advances in Asian Hair Transplantation *Bangkok, Thailand*	International Society of Hair Restoration Surgery *www.ishrs.org* Hosted by Damkerng Pathomvanich, MD	Dr. Damkerng Pathomvanich *path_d@hotmail.com*
August 18-21, 2010	4th Scientific Meeting of the Brazilian Association of Hair Restoration Surgery *Belo Horizonte/Ouro Preto, Minas Gerais, Brazil*	Brazilian Association of Hair Restoration Surgery	*clinica@marcelopitchon.com.br*

HAIR TRANSPLANT FORUM INTERNATIONAL
International Society of Hair Restoration Surgery
303 West State Street
Geneva, IL 60134 USA

Forwarding and Return Postage Guaranteed

FIRST CLASS
US POSTAGE
PAID
CHICAGO, IL
PERMIT NO. 6784

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

2013: 21st ASM, October 23–27, 2013
San Francisco, California, USA