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"WE HAVE EVOLVED"

Editorial by O'Tar T. Norwood, M.D.

*This is the last issue of the **Hair Transplant Forum International** before the new subscription year begins. It is a good time to review the past two years, bring us up-to-date on what's going on presently, and look to the future.*

In reviewing past issues, it is remarkable how fast things are changing. It is amazing how many variations there are and how much improvement can take place in a procedure that at one time seemed so simple and stayed the same for so long. We have evolved through many stages.

1. Two years ago, probably the majority of surgeons were doing large grafts. Now, I am sure, the vast majority are doing **minigrafts and micrografts**. The minigrafts are getting smaller all the time and the number of micrografts is steadily increasing.

2. The number of **grafts** done per session has increased immensely. Four and five hundred per session is not uncommon, and I recently received a report from Austria where they do nine hundred per session. (See Page 8).

3. Originally, most minigrafts were placed in **slits**. **Holes** have gradually increased in popularity and judging from my correspondence and old issues, I believe it is about even, with holes, perhaps, still gaining. There is a place for both, so I believe this controversy will never be completely settled.

4. The **strip** or **knife** method of harvesting is rapidly gaining favor. The knife requires more surgical skill. There is more bleeding, and proper suturing is more important because the wound is deeper, wider, and gaps much more after being cut. Some believe it should be closed in layers.

5. Technically, **transplants** are becoming much more difficult. Cutting the strip with a knife at the appropriate, uniform size is much more demanding. Also, keeping it parallel to the hair follicle requires more skill.

6. A relatively new method of harvesting the donor area was introduced by Bob Limmer, of San Antonio, Texas (Forum - Volume 2, #2), and Marcelo Gandleman of Brazil (Forum - Volume 1, #6). This is

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Tribute

This issue is dedicated to my wife, Mary Ann. The first issue of the Forum was conceived and written in her hospital room, almost two years ago, when she was recovering from cancer surgery. She has proofread and been the inspiration for every issue since. Not only has she helped me with ideas, grammar, syntax and sentence structure, she has, more importantly, given me the confidence to make it possible.

She has helped me write two books and over thirty-five articles on hair transplant surgery, all the time remaining in the background while she proudly and unselfishly pushed my career. She has provided me with confidence, love, and support, not only for the good times but, also, through the bad times, when failure seemed so close.

It is with pride, love, admiration, and gratitude that I publicly acknowledge her indispensable contribution to The Forum, to my career and to my life.

O'Tait Norwood

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called the **elliptical method** of graft harvesting using a single blade. This method is also used by Dr. Jorge Hugeneck of Austria and Dr. Reinhard Kokott of Germany. (See Page 8). Dr. Arturo Sandoval Camarena also uses this method. (See Page 8)(see also Forum - Volume1, #6).

7. **Advertising** has received a lot of attention. It is increasing and, at least in the United States, I do not think it is possible to start a practice without it. Massive advertising by the chains is making it more difficult for individuals in established practices to compete.

8. **X-factor** (unexpected poor growth), denied by some that it even exists, has been discussed. I think this deserves much more attention, and I would welcome comments.

9. **Square grafts**, as revived by Bissaca and Scarbrough, at the ASDS meeting in 1990, started the movement towards the knife. The square graft has been around a long time, but Bissaca and Scarbrough deserve credit for reviving the concept and starting the change from the punch to the knife.

10. **Donor site conservation** was emphasized. Doctors who have been in business for a long time, have learned to respect the donor area. Don't forget, male pattern baldness is progressive and never stops once it begins, so assume the worst case scenario in every patient.

11. The **nomenclature** for minigrafts has changed. The old concept of grafts being quartered or bisected no longer applies now that the knife is coming into vogue.

12. The value of **scalp reductions** continues to receive attention. Overall, scalp reductions are losing favor, but many feel they still have a place.

13. Preoperative **tissue expanders** have been slow to be accepted because of the cosmetic problems they produce during the expansion phase. Kabaker believes they have value with scarring alopecias, limited value with male pattern baldness, and are helpful with flaps and vertex alopecia. He believes that scalp reductions are vastly overrated and much more effective when combined with tissue expansion. Intraoperative tissue expansion has its proponents and opponents.

14. Manfred Lucas emphasized the importance of doing a large **number of grafts** per session, i.e., doing 400 to 500 per session. Bob Limmer of San Antonio, Texas, uses 100 percent micrografts. I believe, to some degree we are all headed toward smaller grafts. Note in the new video tapes(see page 11), Ed Griffin does 100 percent micrografts.

15. Ed Griffin introduced the **graft quotient** concept, correlating graft size to hair type. This certainly warrents more attention.

16. Shiell warned of the **backlash on minigrafts** because of the patients being disappointed in the amount of hair they produce.

17. **Flaps** were discussed by Fleming, Mayer, and Rousso. They appear to have a limited place but are useful, particularly in patients with certain types of hair and high motivation. The **Marzola/Brandy scalp lift** is slowly gaining in popularity as more and more people become proficient

with it.

18. The problem of **fees** repeatedly comes up. With the number of grafts increasing, and the doctors charging by the graft, the fees can become quite high. More and more doctors are charging by the session or by the area covered.

Indeed, the field of hair transplantation is changing continuously. The rapid change in existing procedures and the emergence of new issues make frequent and open communication between practitioners of this art a necessity. The ***Forum*** is dedicated to fostering continuing discussion and debate between practitioners. Your contributions are enthusiastically welcomed.

Misrepresentation of MiniGrafts

Fees and Protocol

by Dominic A. Brandy, M.D.

The following was written specifically for publication in the ***Hair Transplant Forum International*** *concerning problems it's author has seen develop over recent years.*

Recently, I have seen an increasing number of disheartened patients who have had minigrafting performed in hair clinics, hairpiece salons and even some doctors' offices. Their main complaint is not so much that the quality of the work is bad, but that they have been deceived. It seems that many of these patients are being told during their initial consultation that 2-4 sessions of 50-100 mini-micrografts per session will develop a 7-8 cm wide hairline and, in some cases, will treat the entire crown and hairline. These patients often become very disillusioned when they see that the hair yield from one of these mini-micrograft sessions is scant. In other cases, they become disillusioned with the whole process and decide not to finish the work that was begun.

New Techniques Create New Problems

Over the past five years, more and more hair replacement surgeons have begun transplanting mini and micrografts instead of conventional grafts for the treatment of male and female pattern baldness.

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CAUTION

WITH MINIGRAFT EXPECTATIONS

Quotes from Richard Sheill, M.D.

This is a continuation of the ongoing discussion between Dr. Pouteaux and myself.

"I have really never disagreed with any of Dr. Pouteaux's points, but have only urged caution on the part of surgeons new to hair transplants. Of course Dr. Pouteaux and I rarely get complaints about minigraft density, as we select our patients carefully and counsel them thoroughly".

"This is exactly what I was trying to get across in my article, when I warned about a possible minigraft "backlash". Many doctors with high overhead and low patient numbers tend to promise more than they can possibly achieve, when first interviewing patients. This may result in disappointing results later".