Message from Paul J. McAndrews, Program Chair of the 2010 Annual Meeting

Dear Colleagues:

I am very excited about the upcoming 18th Annual Scientific Meeting of the International Society of Hair Restoration Surgery. The meeting will be located in the great city of Boston, Massachusetts, from October 20-24; therefore, mark it on your calendar and save the date!

This year's theme is: REVOLUTION & EVOLUTION—Advances in Hair Restoration: Revolutionary Concepts and Evolutionary Techniques. We had an unbelievable response to the call for abstracts. We received the most abstracts ever in the history of the annual meeting. As such, we anticipate a very successful meeting full of very interesting talks. Our keynote speakers who have agreed to speak are Dr. Bruno Bernard and Dr. Kurt Stenn.

Please see below for our preliminary outline for the meeting (subject to change).

I am looking forward to creating a revolution in Boston in 2010 with all of your help. Bringing tea is optional; however, coming from an Irishman, bringing beer is encouraged.

Sincerely,

Paul J. McAndrews, MD

Chair, 2010 Annual Scientific Meeting

Preliminary Outline for 2010 Boston Annual Scientific Meeting

Tuesday/October 19, 2010

9:30am-2:30pm	Live Surgery Workshop

Wednesday/October 20, 2010

8:00AM-4:00PM	Board Review Course
9:00AM-4:00PM	Basics in Hair Restoration Surgery Course (hands-on)
9:30AM-4:00PM	Surgical Assistants Program and Luncheon
9:30AM-3:30PM	ISHRS Board of Governors meeting
1:00PM-7:00PM	Exhibits Set-up
4:30PM-5:30PM	Newcomers Orientation & Reception
5:30PM-8:30PM	Ancillary Meeting – ABHRS Recertification Exam
6:00PM-7:30PM	Global Council of Hair Restoration Surgery Societies Meeting

Thursday/October 21, 2010

6:45AM-8:15AM	Workshop 101: FUE – "how to" hands-on training session with cadaver; aimed toward doctors who want to learn how to do it and try different techniques
6:45AM-8:15AM	Workshop 102: Recipient Sites – hands-on, different techniques & instruments
6:45AM-8:15AM	Workshop 103: Painless Anesthesia Techniques
6:45AM-8:15AM	Workshop 104: Pearls for Maximizing Graft Survival and Avoiding Poor Growth
6:45AM-8:15AM	Workshop 105: Surgical Assistants Cutting/Placing Workshop – hands-on with cadaver
7:45AM-7:00PM	Exhibits
8:45AM-12:15PM	General Session
12:30PM-1:45PM	Lunch Symposium 111: Powered FUE – no CME credit
12:30PM-1:45PM	Lunch Symposium 112: Open Microphone on Complications
12:30PM-1:45PM	Lunch Symposium 113: Social Media
2:00PM-5:30PM	General Session
5:30PM-7:00PM	Welcome Reception
7:00PM-9:00PM	Ancillary Meeting – ABHRS Board of Directors meeting

Friday/October 22, 2010

6:30AM-6:00PM	Exhibits
6:45AM-8:00AM	Workshop 201: Fellowship Training Program Educators Workshop: How to Present at Medical Meetings
7:00AM-8:00AM	Breakfast with the Experts: Round 1
8:15AM-12:15PM	General Session
12:30PM-1:45PM	ISHRS Annual Business Meeting Luncheon and Service Awards
2:00PM-5:30PM	General Session
6:00PM-7:30PM	Annual Giving Fund Reception

Saturday/October 23, 2010

6:30AM-1:30PM	Exhibits
7:00AM-8:00AM	Breakfast with the Experts: Round 2
8:15AM-12:00PM	General Session
12:00PM-1:00PM	Lunch on own – lunch for purchase in exhibit hall; exhibits until 1:30PM
1:00PM-2:00PM	General Session
2:00PM-3:30PM	Live Patient Viewing
7:00PM-12:00AM	Gala Dinner & Dancing & Awards Ceremony

Sunday/October 24, 2010

8:00AM-9:00AM	CME Committee meeting
9:00AM-12:00PM	General Session
12:00PM	Conference adjourns

CALL FOR NOMINATIONS

2010 Follicle Awards

GOLDEN FOLLICLE AWARD — Presented for outstanding and significant clinical contributions related to hair restoration surgery.

PLATINUM FOLLICLE AWARD — Presented for outstanding achievement in basic scientific or clinically-related research in hair pathophysiology or anatomy as it relates to hair restoration.

DISTINGUISHED ASSISTANT AWARD — Presented to a surgical assistant for exemplary service and outstanding accomplishments in the field of hair restoration surgery.

How to Submit a Nomination:
Include the following information in an e-mail to: info@ishrs.org

- Your name,
- The person you are nominating,
- The award you are nominating the person for, and
- An explanation of why the person is deserving; include specific information and accomplishments.

Nominating deadline: July 1, 2010

See the Member home page on the ISHRS website at www.ishrs.org for further nomination criteria. All awards will be presented during the Gala at the ISHRS 18th Annual Scientific Meeting, October 20-24, in Boston, Massachusetts, USA.

2010 Research Grant Application Deadline: June 30

Research Grants Available

1. The annual ISHRS research grants with amounts in the range of $1,200 to $2,400 USD per grant.
2. In addition, one grant is being offered for US $10,000 via a joint program between the ISHRS and the International Hair Research Foundation (IHRF).

The deadline for all grant applications is

June 30, 2010

Further information and a full application can be obtained on the ISHRS website at
http://www.ishrs.org/member-grants.htm

Call for Editors for the ISHRS *Forum*

We are looking for two ISHRS physician members to fill the positions of *Forum* Co-Editors for the term March/April 2011–January/February 2014, which equates to 18 issues. These are uncompensated, volunteer positions, but very rewarding nonetheless!

Interested members should forward an e-mail to ISHRS headquarters office at info@ishrs.org and vceh@comcast.net by June 1, 2010, indicating their intent. The Executive Committee will review all candidates and make a determination at its June 2010 meeting. Candidates will be notified in July.

Duties

- To produce 6 issues of the *Forum* per year within the pre-established time line. The *Hair Transplant Forum International* is the ISHRS's official publication. It is not peer-reviewed and is considered a newsletter.
- The co-editors may wish to alternate issues as the "lead" editor, thus, serving as the lead for 3 of the 6 issues per year. The "lead" editor can expect to spend 10–20 hours per issue. The non-lead editor can expect to spend 4–6 hours in helping with proof review.
- One of the two editors should serve as the primary point person in regards to submitted articles from the membership. All articles are required to be submitted electronically via e-mail. Staff at ISHRS headquarters provides copy relating to Society announcements.
- Each co-editor writes a "Message from the Editor" on any topic he or she wishes for each issue.
- Co-editors have the discretion to determine which articles to include.
- The physician co-editors work with the Managing Editor (staff person), Cheryl Duckler, by forwarding the articles to include for a particular issue. The Managing Editor lays out the issue and both co-editors review the proofs, which are e-mailed as a PDF file before signing off to go to print. The printing and mailing is handled by ISHRS staff.

Qualifications

The editor must:

1. be an experienced hair transplant surgeon;
2. have experience in publishing papers in the Forum or in any other peer-reviewed journals or textbooks, because this experience gives you familiarity with the reviewing process of papers;
3. appreciate the diversity of approach represented by members of the ISHRS and not show favor to any particular "niche" technique;
4. have the ability to write easily and fluently in English;
5. be computer and e-mail literate and not have to rely on a secretary as an intermediary (or work will grind to a halt after office hours, when most of the editors' work is usually done); and
6. be organized and adhere to deadlines.

Send e-mail to **vceh@comcast.net** and **info@ishrs.org** by June 1, 2010, to be considered for the position of *Forum* Co-Editor.

Regional Workshop Applications Due: June 1

- Are you an educator?
- Do you have a good idea for a workshop?
- Can your surgery center host a live surgery workshop?
- Is there a specific educational need of the hair restoration physicians in your area?

If you would like to partner with the ISHRS and host a local live surgery workshop, please submit your completed application to **info@ishrs.org** by **June 1, 2010**.

Application materials may be obtained at
http://www.ishrs.org/member/member-workshop.php

ISHRS Annual Giving Fund Annual Report

Dear Colleagues:

2009: I am proud to report that, in the midst of the current state of the economy, the ISHRS Annual Giving Fund is staying the course. Our goal was to earn $67,000 in donations in 2009 and we surpassed our donation goal and collected $73,000. While giving decreased modestly from 2008, it did grow more than expected. Thank you to all who contributed so generously. THANK YOU! Each of you has helped further the ISHRS to realize its goals and provide valuable member benefits.

After direct costs and expenses were accounted for, the proceeds from the past year's Annual Giving Fund were used to support several projects from the target list of priority projects, including increasing international public awareness through website improvements, providing offshore annual meetings, and furthering support of OPERATION RESTORE.

2010: In 2010, we have earmarked $15,000 for the ISHRS website marketing effort to better position www.ISHRS.org on search engines; $7,500 toward a partial purchase of an Audience Response System (ARS), which will allow interactivity between our presenters and their audience; and we've allocated $23,500 of continued support for OPERATION RESTORE to help more pro bono patients with travel and hotel expenses.

We look forward to another successful year and welcome those who are not yet donors to join in! For those who have not yet contributed, it's easy to support the Society. Go to: http://www.ishrs.org/ishrs-giving-fund.htm. New donors will receive a lapel pin, and we ask you to wear it proudly at the ISHRS meetings.

2010 AGF Reception: To show our recognition for 2010 donors, we will again organize the President's Annual Giving Fund Reception during the 2010 Annual Scientific Meeting in Boston this October.

We are thrilled to provide donors and potential donors access to one of the most well-known historic venues on Boston's Waterfront. This year's reception will be at held the Exchange Conference Center, which is housed in the building that was originally the New England Fish Exchange, home of the Boston Fish Auction. Come enjoy an assortment of their specialties right on the Boston Waterfront…it can't get any fresher than that! (There will also be plenty of selections for those who do not eat seafood.)

We will celebrate the generosity of our members and highlight the AGF-supported initiatives and projects. The Annual Giving Fund will provide two (2) complimentary tickets to our Trustee and Leadership Circle donors. All donor categories may purchase (additional) tickets at a special price of $90.00. For those who are not donors of the Annual Giving Fund, come and learn what the AGF is all about. Tickets can be purchased for non-donors at a price of $110.00 per person.

Your generosity makes a statement that you support the ISHRS and its initiatives. Thank you for your consideration of a gift to the Annual Giving Fund. All gifts are tax-deductible within provisions of your national income tax laws. Should you need additional information, please contact the ISHRS Headquarters at 630-262-5399.

Most sincerely,

Matt L. Leavitt, DO Chair, Annual Giving Fund

The goal for the 2010 Annual Giving Campaign is $69,500 from current and new donors.

Thank You to Our 2009 Donors

The ISHRS gratefully acknowledges the generosity of the following individuals who made donations in 2009 to the Annual Giving Fund.

TRUSTEE CIRCLE: $2,000

Alan J. Bauman, MD
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Surgeon of the Month: Robert Reese, DO

Samuel M. Lam, MD, FACS *Dallas, Texas*


Robert Reese, DO

Surviving an open-heart surgery at 14 years of age for a defective valve, Robert Reese proved to be a stalwart individual who has continued in his path to refine and redefine the field of hair restoration. On the Board of Directors for the ABHRS and as the chair for the written examination, Bob works to help ensure that the high banner of quality hair restoration flourishes: "My philosophy centers on creating conservative adult-level hairlines that will stand the test of time and look natural even if the patient continues to lose hair." This approach has served him well in creating high patient satisfaction and natural results that have earned him the rightful place as the Surgeon of the Month.

Born December 17, 1958, in San Rafael, California, Bob's parents relocated to Minnesota shortly after his birth. The second oldest child of Richard and Joy Reese, Bob has two brothers and two sisters. His parents, who hail from modest means, sacrificed much in hope of creating a better future for their children. Accordingly, all five children attended Catholic schools, and Bob was even an altar boy in his youth. Continuing in his Catholic schooling, Bob attended the college at St. John Abbey & University in Minnesota. Being part of an all-male campus, Bob recalls fondly, "I remember walking across campus many nights after studying for exams and hearing the monks perform Gregorian Chant."

After college, Bob attended Des Moines University College of Osteopathic Medicine and Surgery and then completed General Surgery residency in Cleveland, Ohio, and a fellowship in Peripheral Vascular Surgery at St. John Hospital & Medical Center in Detroit, Michigan, in 1993. Bob practiced General and Peripheral Vascular Surgery in Buffalo, New York, where he held a teaching post at SUNY Buffalo College of Medicine and was Clinical Assistant Professor of Surgery at the New York College of Osteopathic Medicine.

Two patients who were referred for pelvic aneurysms oddly enough altered his professional course toward the field of hair restoration, which Bob admits at the time he "quite frankly didn't even know existed as a profession." As Peripheral Vascular Surgery was moving apace toward minimally invasive techniques, Bob thought that he would need another fellowship to remain at the forefront of his profession. Seeking career guidance from the University's counselor and after completing a battery of tests, he found that the field of hair restoration offered him the balance of what he loved: being a fine, technical surgeon and enjoying the freedom from emergency patient care.

With that advice in mind, he attended the ISHRS meeting in San Francisco in 1999 and was "incredibly impressed with the organization and the physicians." Completing a fellowship in hair, he trained under the supervision of Drs. Manuel Oscar Jaffe, Craig Ziering, and Melvin Mayer, "all of whom I have the utmost respect for to this day." He worked with a national hair restoration clinic (where he originally trained) until May 2004 when he opened his own private practice in Edina, Minnesota (a suburb of Minneapolis), where he continues to practice under the aegis of Reese Hair Restoration.

Board certified by the ABHRS and actively working on behalf of the board, Bob has also contributed to the advancement of the field with two studies on activated platelet rich plasma (PRP) as a storage medium and as a topical wound healing accelerant to the transplanted scalp. The results of both studies showed statistically significant benefits when modern hair transplantation was performed in conjunction with activated PRP. Bob believes, "Having followed these patients for the past four years, it is my firmly held belief that the addition of activated platelet rich plasma should become the routine 'gold standard' for modern hair restoration surgery."

Performing only one surgery a day, Bob believes that patient care is a priority for him. He says, "Most commonly I perform microscopic follicular unit transplantation utilizing a trichophytic donor closure. To a lesser extent I do perform multi-unit grafting and follicular unit extraction when indicated." He believes that he can attain a very acceptable result with a single pass in the majority of his patients. Being conservative and careful are hallmarks of his operative style in order to ensure long-term patient success with his outcomes.

Turning 51 years old, he says that he doesn't "look a day over 49 and half." He has two children: Jessica, a 17-year-old senior at Totino-Grace High School, and Seamus, an 8-year-old third-grader at the Holy Name of Jesus School. Jessica loves soccer, and Seamus loves baseball (especially the Minnesota Twins), soccer, and basketball. He cites a "boring" life consisting of attending his children's activities and coaching their performance in sports.

Dr. Robert Reese is deserving of the distinction of Surgeon of the Month by virtue of his outstanding clinical achievements, ongoing scientific contributions, and his leadership roles in our field. Congratulations, Bob!✧

Review of the

Literature: Dermatology

Marc R. Avram, MD *New York, New York;* Nicole E. Rogers, MD *Metairie, Louisiana*

Dermatomyositis and Hair Loss

Citation: Tilstra, J.S., et al. Scalp dermatomyositis revisited. *Arch Dermatol.* 2009; 145:1062-1063.

Dermatologists in Pittsburgh recently investigated the incidence of hair loss in the setting of dermatomyositis (DM), an autoimmune disorder resulting in proximal muscle weakness, a heliotrope rash, Gottron papules over the dorsal MCPs, the "shawl sign" (erythema over the shoulders and back), and risk of associated malignancy in some 20% of cases. This team performed a retrospective review of 24 cases of DM identified between 2003 and 2008. They found that 15 of the 24 cases had scalp involvement, with one-third (n = 5) exhibiting non-scarring hair loss. They described the scalp changes as diffuse and scaly with erythema. All 15 were women, and only 1 had associated malignancy. The report went on to discuss how patients treated early on with either methotrexate or mycophenolate mofetil (Cellcept) had better improvement in their scalp symptoms than patients treated with hydroxychloroquine (Plaquenil).

Comment

Hair transplant surgeons of all backgrounds can be reminded of this insidious and often difficult to identify condition. Its presentation may appear to overlap between telogen effluvium (shedding) and psoriasis (white shiny scale). The scalp biopsy is a helpful way to identify this condition, demonstrating interface changes similar to those seen in lupus. It is also essential to consider other elements of the condition, including skin findings, muscular weakness, and incidence of malignancy.✧

Where Have All the Melanocytes Gone? Long Time Passing...

Citation: Trautman, S., et al. Melanocytes: a possible autoimmune target in alopecia areata. *J Amer Acad Dermatol.* 2009; 61:529-30.

There is still extensive speculation about the etiology of alopecia areata. Most agree that there is some component of autoimmune action against a part of the hair follicle. However, we still do not know what part of the follicle or what antigen triggers this attack. A recent histologic study by dermatologists in Portland investigated the density of melanocyte staining in 18 patients with alopecia areata and compared this with the density of melanocyte staining in 5 normal controls. They found that there was 3+ staining in all 5 of the controls, but 13 of 18 patients with AA had only trace to 1+ staining of melanocytes. Three of 18 had 2+ staining and 2 had 3+ staining. The study showed that there was a decreased number of follicular melanocytes in alopecia areata. Limitations were that it did not clarify whether the melanocytes were decreased because of autoimmune attack or because of rapid hair cycling.

Comment

We report on a finding published in the *Journal of the American Academy of Dermatology* that demonstrates a reduced density of melanocytes in alopecia areata. This phenomenon is not unfamiliar to most hair specialists, who have observed poliosis, or whitening of associated hairs during the regrowth period. Hopefully, the results of this small study will give us more insight into this psychologically disturbing and unstable condition.✧

Latisse®—Not Efficacious for Eyelash Alopecia Areata

Citation: Ochoa, B.E., et al. Instilled bimatoprost ophthalmic solution in patients with eyelash alopecia areata. J Amer Acad Dermatol. 2009; 61:530-32.

The introduction of Latisse, or bimatoprost, for thickening and lengthening of lashes has created a possibility for seemingly unlimited applications in the realm of hair loss. One team of researchers recently tested its efficacy in the treatment of alopecia areata (AA) of the eyelashes. Participants had to have at least 50% eyelash loss for a period of longer than 6 months. In a prospective, open-label trial, participants were asked to apply bimatoprost ophthalmic solution directly to one of their eyes, while leaving the other eye untreated. Eleven patients were enrolled and 7 completed the study. They were followed every 4 weeks for a total period of 16 weeks. The results indicated that bimatoprost was not effective in regrowing lashes in 5 of the 7 patients. The two patients who showed promising results had less extensive eyelash loss caused by alopecia areata. The authors commented that these results were consistent with the finding elsewhere that patients with less than 50% scalp involvement of AA generally had a better response to treatment.

Comment

Latisse and the other prostaglandin analogs are promising in the treatment of hair loss. Alopecia areata is a condition that has so far eluded clinicians and researchers alike. The mechanism of action of bimatoprost does not have any immunosuppressive action, which presumably explains its lack of efficacy in this condition. We are still awaiting large studies using bimatoprost for the treatment of androgenetic alopecia although its use for this application appears, so far, to be limited by cost and availability.✧

Review of the

Literature: Book Review

Richard C. Shiell, MBBS *Melbourne, Australia*

Citation: Hair Restoration Surgery in Asians. (2010). D. Pathomvanich & K. Imagawa (Eds.), 266 pages, Springer.

Is there a market for another textbook on hair transplant surgery? When the target audience is an ethnic group that makes up more than half of the world's population, then the answer must be a resounding "yes." It is not as if Asians have been ignored in past textbooks on Hair Transplantation, but at most they have received only a few pages.

This compact and attractive textbook published by Springer has been assembled from the work of 13 Asian authors (10 surgeons, 2 nurses, and 1 dermatologist), some of whom are well-known in the West. It has been tightly edited by the very respected and experienced hair transplant surgeons Drs. Damkerng Pathomvanich from Thailand and Kenichiro Imagawa from Japan, and makes interesting reading. It is well-illustrated in color and there is a good Table of Contents and a detailed Index.

The authors do not attempt to define what they mean by "Asians" but, after reading the book, I concluded that for the purposes of this book they mean individuals who originated from Southeast Asia. This includes Japan, Korea, the Philippines, Malaysia, Singapore, Thailand, Vietnam, Cambodia and the southeast regions of China. There is only one author from the Indian subcontinent, and very little mention is made of any of the ethnic groups seen in this very populous region.

The book is not intended to replace the existing established texts but is a supplement to them and will find a place on the bookshelf of all surgeons with a significant number of Asian patients. The only criticism I could make is that, in an attempt to provide clarity and a freedom from repetition, many of the chapters are a little too concise and one is expected to continually refer to the established texts for more detail. I realize that it is difficult to strike a happy medium, and I am sure that this balance will be adjusted in later editions of this excellent book. I would also like to read further chapters dealing with the specific problems seen in patients from India, Pakistan, and Sri Lanka, all of whom are being seen in increasing numbers in our practices in the West. With the rapid rise of interest on the subcontinent and the rapid expansion of the Indian Society of Hair Restoration, I am sure that many more authors will soon become available to contribute to future editions.✧

Letters to the Editors

Ali Vafaei, MD *Tehran, Iran*

Re: The Cohen Hair Loss Classification System

With many thanks for your very helpful Forum magazine, I have some suggestions about the Cohen Hair Loss Classification System (*Hair Transplant Forum Int'l.* 2009; 19(6), p. 195).

To be honest, the 50-year-old Hamilton and Norwood (H-N) system is very useful, but it's very simple too, has some limitations, and does not have enough sensitivity and specificity to meet the high standards of today's hair transplant options. There are so many variations in androgenetic alopecia patterns that such a simple set of black and white drawings cannot precisely define its many types and models. During years of doing hair transplant surgery, I always feel that we need a more sophisticated method of classification, and when I saw Dr. Cohen's paper in the *Forum,* I became very happy. It is a great step forward in a better understanding of androgenetic alopecia and its classification.

As I saw the map and chart, I noticed some points in them that if corrected (in my opinion) may increase its accuracy and sensitivity:

1. Under number 1, there is one column in the chart, but in the map, we see 2 parts (right and left) showing area number 1. If, for example, a patient has minimal hair loss in the left No. 1 side, but the other No. 1 side has moderate hair loss (this is rare but does occur especially when the patient has undergone a previous hair transplant session, particularly if it has not been done well), we cannot depict this matter in the chart correctly. I think there must be 2 columns (left and right) under area No. 1.
2. The same is true for No. 2. The area covering area No. 2 is narrow and long. I think three columns are better than two. One for the left side, one for the right side, and the third for the middle part of area No. 2. This way we can show an anteriorly-placed forelock more precisely.

Again, I offer my great thanks to Dr. Bernard Cohen for introducing such a helpful classification.✧

IN REPLY

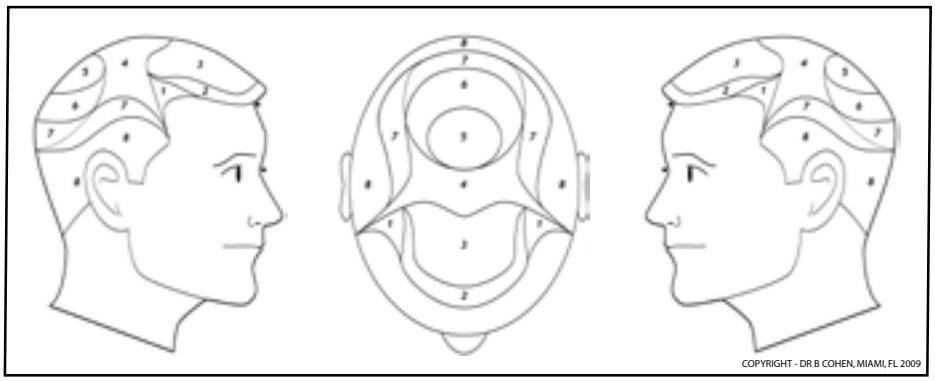
Bernard H. Cohen, MD *Coral Gables, Florida*

Re: In Response to Dr. Vafaei

The system is a delicate balance of mathematics, anatomy, and historical precedent. When multiple zones are configured in combination, an established Norwood pattern is created. A precise proportionality exists between the anatomic surface area of a single zone and the number of columns assigned to that zone. Each column of 5 cells equals 5% of the scalp surface area. Zone 8 contains 5 columns and represents 25% of the surface area. The remaining 7 zones have been assigned columns proportionate to the relative size of their surface area on the scalp. To assign more columns to Zones 1 and 2 would destroy the relationship of one zone to another, and compromise the utility of the system.

Three years ago, when the system was first introduced, it had the same 100 cells, but was divided into more than 8 zones. It never gained acceptance by the hair restoration community. Feedback indicated it was "too complex." In response, the system was redesigned—it may now be used at several levels of complexity. One may score the Regions alone, score Zones alone, or score subdivisions of major Zones, or combinations of each—use the system in any manner that suits your personal style. To incorporate even more flexibility, as suggested by Dr. Vafaei, would have meant re-introducing the complexity of the previous system.

The issue of asymmetry in Zones 1 and 2 can be addressed by hand drawing the asymmetric hairline directly



Eight zones and 3 regions identify the areas of scalp most commonly affected by male pattern balding. The blank 100-cell table is penciled in to become the hair loss Profile. The hair loss Index is entered in the small box. Tumors, scars, irregular patches of loss, etc., may be drawn directly on the topographic illustrations. *To receive a free electronic copy of the above Map and Chart, contact the author at bcmd@mac.com. Copyright requires signed permission to publish or reproduce this material for sales, advertising, or other commercial purposes.*

on the illustration and making appropriate changes to the Hair Loss Index value. In fact, drawing directly on the illustrations is encouraged. It serves to document hairlines that are very anterior, asymmetric, or unusually irregular. I usually pencil in the measured distance between the dots, directly on the illustration—in the space between the dots. (The measured width of Zone 5 or 6 can be entered on the illustration as well.)

I also sketch directly on the Map & Chart during HT consultations to demonstrate the sequential nature of pattern balding, the concept of moving "hair-containing cells" from one zone to another, the anticipated shape of the final hairline and vertex borders, the number and size of grafts planned for each zone, etc.✧

Bernard Cohen, MD *Coral Gables, Florida*

Re: The Trichometer and Its Clinical Utility for Evaluating Early Onset Hair Loss

I read with great interest the exchange of ideas about the AR genetic test between Dr. Simmons and Keene in the January/February Dissector article (The clinical utility of the AR genetic test, *Hair Transplant Forum Int'l.* 20(1), p. 26). A question was raised: will AR genetic testing truly help our patients in terms of motivating early treatment, managing stabilization programs, offering reassurances, and reducing anxiety? Dr. Simmons concludes that the test has minimal clinical utility. Dr. Keene feels quite the opposite. I would like to add my input suggesting a different approach that might indeed help to solve this dilemma. Before proceeding, I respectfully disclose a conflict of interest by my patent ownership of the Trichometer and HairCheck technology.[1]

It seems illogical to use photographs for detecting and tracking early-onset hair loss. My opinion is based on the teachings of Marritt, who clearly demonstrated that 50% of the hair must be lost before hair loss is visible to the naked eye.[2] A patient who has no visible hair loss would have a photograph that shows no visible hair loss. A photograph will not serve as a detector or quantitative assessment, if the patient has less than a 50% hair loss at the time the photograph is taken.

If, however, the HairCheck device is substituted for the camera, the approach to, and management of, the same patient becomes simple. The issues of early detection and predicted severity become easy to understand, explain, and quantify. The HairCheck measurement of a single site can be performed by a tech in less than 3 minutes. A quantitative hair mass score of 1-100 is immediately generated. Compare that to a camera. It has no quantitative capability, and timewise it's more consuming when one considers the need to shoot, download, view, compare, and file. Here's how the HairCheck device may be used to manage patients with hair loss...hair loss that may, or may not, be clinically visible.

A 20-something-year-old man, fearful of hair loss, arrives for consultation. He has a strong family history of balding. He has no visible hair loss, but he suspects he has less hair than before in the mid-frontal area. After performing a quick examination, I ask one of my techs to "HairCheck" one site in the permanent fringe and one site in the area of suspected loss. The Hair Mass Index (HMI) of each site is noted. The values reflect the density and diameter of hair in the isolated bundle. Results: The patient's mid-occipital fringe has an HMI of 95, so 95 becomes the "control" HMI for that patient. (If he had fine hair, or an average density of less than 230 hairs per cm^2, his "control" would be lower; if he had coarse hair or a higher density, the "control" would be higher) The suspected area of loss has an HMI of 83. Conclusion: The patient has a 13% hair loss in the suspected area of loss. (95–83/95 × 100). The HMI reduction is due to early diameter reduction—too subtle to be quantified by hair counts or video microscope. At this juncture the hair loss has been detected and expressed as a meaningful number. No visual judgments have been made. The patient now knows exactly where he stands in Marritt's *non-visible range* of 1-50% hair loss. The results are discussed and because his loss is minimal, my treatment suggestions are postponed until his following visit.

Then the patient returns in 6-12 months. The mid-frontal area of non-visible loss is measured once again. A special re-locating system that's included with the HairCheck ensures that we return to the same site, without the need for scalp tattoo. On this visit, the HMI of the mid-frontal site has dropped from 83 to 79. With this updated information, the discussion goes something like this: "Your hair loss in the frontal area is 5% worse than it was last year (83–79/83 × 100). We can measure the site once or twice a year to see if the HMI stabilizes, improves, or continues to drop. Over several years, we can even average your annual rate of loss. On the other hand, we can start minoxidil, finasteride, or laser and see what effect they have on the HMI. We can document with scientific accuracy, if they are working, and how well they are working. Should the HMI drop below 50% of the control HMI—only then will the loss become visible and documentable on camera."

What have we accomplished? The patient with non-visible loss knows *how much hair* he has actually lost. Depending on this value, he may or may not be motivated to start treatment early. If he chooses no treatment, he has the opportunity to track the rate at which he is losing his hair. An annual loss of 3% has different predictive implications than an annual loss of 20%. If he chooses to begin treatment, both he and his physician will know exactly how well the treatment is working, and how well the loss has been stabilized.

References:

1. Cohen, B.H. The cross section trichometer: A new device for measuring hair quantity, hair loss, and hair growth. *Dermatol Surg.* 2008; 34:900-910.
2. Marritt, E. The death of the density debate, *Dermatol Surg.* 1999; 5:654-660.✧

⇨ page 68

Letters to the Editors
from page 67

Richard Rogers, MD *Warwickshire, United Kingdom*
rikrogers@aol.com

Re: Tinnitus and Deafness: Rare Finasteride Side Effects

I would like to report a rare side effect of finasteride, as experienced by a patient of mine.

He is a fit and healthy 40-year-old male, with no known allergies, who had never tried finasteride previously.

Approximately one hour after his first dose of 1mg Propecia®, he noticed tinnitus and unilateral deafness, which improved spontaneously over the next 12 hours. Unsure whether this was coincidence or a side effect, he took his next daily dose as prescribed, 24 hours after the initial dose. He then experienced unilateral earache, deafness, and tinnitus within 30 minutes of this dose. This time, his symptoms did not dissipate spontaneously and he telephoned me for advice on day 3.

I researched on the web, which came up with a couple of similar reports. I also contacted the manufacturers (MSD) in the U.K., who could only find one reported case. Unfortunately, that case did not report a conclusion. However, two of the reports on the Internet suggested prescribing antihistamines (assuming some sort of allergy reaction) and this seemed sensible.

I suggested this to my patient who bought antihistamines from his local pharmacy, as his symptoms still had not resolved after 5 days and this seemed to help, as his symptoms did then resolve by day 7.

Although tinnitus is a known side effect of finasteride, it appears to be very rare and temporary. The likely explanation is an allergy reaction causing swelling of the eustachian tube, leading to deafness and tinnitus. Treatment with antihistamines appears to be suitable and effective.✧

Muhammad Ahmad, MD *Rawalpindi, Pakistan*

Re: Rare Complication of Forehead Taping

Hair restoration surgery is increasing in popularity especially with the increasing safety and greater aesthetic outcome associated with modern techniques. Today's hair restorative surgeon, however, is faced with many challenges and there are always some unexpected complications.

A patient undergoing follicular unit transplantation under local anaesthesia including supraorbital/supratrocheal blocks presented on the 2nd postoperative day with two small abrasion-like friction burns (0.7mm × 0.9mm) over the eyebrows. These were noticed after removing the initial bandage used to support the donor area overnight. The patient was reassured and was managed conservatively. He was also advised to protect the wound from sunlight in order to prevent it from hyperpigmentation.

In some patients having hair transplant surgery, the forehead is taped with an elastic bandage (Co-Flex) overnight to support a donor site dressing. If the bandage is too tight or there is postoperative edema, then there is the likelihood of developing small pressure/friction-like burns as occurred in this case.

There are a few options to avoid this. First, if a bandage is used, it should be a bit loose on the forehead. Secondly, the postoperative removal of the bandage should be achieved without upward drag, minimizing friction. Finally, some material should be placed between the skin of forehead and the elastic bandage providing a slippery interface that can lessen the friction.

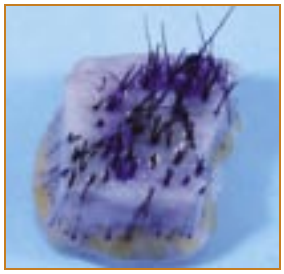
The surgeon must always be vigilant enough to foresee the problem and should make attempts to avoid unexpected issues.✧

Michael Beehner, MD *Saratoga Springs, New York*

Re: A World Record of 10 Hairs in a Single FU

I have these three photos of what I will propose is the world's record to date for number of hairs in a single follicular unit. A couple of years ago, I came across this one patient with a multitude of 5-, 6-, and 7-hair FU bundles in his donor hair, and one even had TEN follicles (with terminal hairs) in a single bundle. The photos below show two different views of this graft, and the small section of donor tissue shows where this graft came from and gives an idea of the large number of follicles per FU that the rest of its neighbors possessed also.

I am happy to see someone break this record, but wanted to submit this graft in case it actually was the leader at this time.✧



Surgical Assistants Editor's Message

Laurie Gorham, RN *Boston, Massachusetts* laurieg@bosley.com

Happy Spring Assistants!

Spring has just about arrived; thankfully. Now that the long winter is almost behind us, remember we are always looking for tips, ideas, and articles for Surgical Assistants Corner. Please send in your submissions. Time for some spring cleaning of your files for that article that you wrote but never quite finished! We'd love to hear how you train your assistants, how you maintain quality control, how you keep those joints and fingers nimble, or what placing forceps you prefer and why. I can't wait to see what blooms in the next few months! Happy Spring Everyone!

Laurie Gorham, RN

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

Quality control pertinent to surgical assistant tasks

Emina Karamanovski, MD, Lam Institute for Hair Restoration, *Plano, Texas* emina@hairtx.com

Quality control (QC) in hair restoration has not been addressed in a systematic way in the past. However, addressing QC in hair restoration is necessary in order to ensure that services related to hair transplantation surgery are designed and delivered to meet or exceed patient requirements.

Although hair restoration is a team effort and, therefore, QC should be the responsibility of the entire team, this article addresses only the portion of these responsibilities pertinent to surgical assistants during the surgical portion of QC, which includes slivering, graft dissection, and graft placement. Surgical assistants should keep quality standards in mind and continually check their work against those standards. In order to strive for quality, we have to outline mistakes so that we know what to avoid or how to correct specific missteps.

Quality control is a continual process that consists of setting specific quality standards relevant to obtaining desirable results, monitoring their implementation, and identifying, as well as providing guidelines for correcting, one's mistakes. Quality standards for hair restoration have two objectives: 1) maximum yield from transplanted hair, and 2) undetectable, naturally looking re-grown hair.

Quality control is also a process of constant monitoring one's work for possible mistakes. Accordingly, mistakes that may occur during hair transplantation surgery are grouped around those that can compromise hair yield and/or naturalness. All possible mistakes made by the surgical assistant are "human factors" because they cannot be blamed on faulty equipment. The most common mistakes committed by surgical assistants revolve around the following:

1. Trauma
   - Hydration (drying out)
   - Handling (physical damage)
2. Technique
   - Lack of dexterity
   - Lack of attention
   - Lack of knowledge

Trauma. Damage done to the hair bulge, hair shaft, or hair bulb can lead to poor results. Trauma can be inflicted during slivering, dissecting, and placing grafts. Drying out of slivers or grafts can result in poor growth (fewer than the transplanted hairs growing back with insufficient "coverage"), or in an absence of growth (visible empty spaces where grafts were placed during the procedure but with no subsequent hair growth). Physical damage to the hair bulge or hair bulb caused by forceful manipulation (e.g., squeezing with forceps) may result in kinky-looking hair or poor/sparse growth.

Technique. Negligence to pay attention to proper technique can cause unnatural results. The following four deficiencies are mostly related to graft placement technique:

1. Improper graft size to site size fit may cause *pitting* or ingrown hair. If a graft is too large for a site, and it has to be forced and squeezed to fit, it will most likely create a pitted result. Pitting appears as a small scalp indentation around the hair exiting point, making the scalp look rough and unnatural. If a graft is too small, it may slide inside the site, leaving the site looking empty, which in turn may falsely encourage the surgical assistant to put another graft into the same site. This is called *piggybacking* and it often results in ingrown hairs.
2. Another technique error relates to the selection of grafts according to the pattern, thus making a proper graft selection for recipient site location. For example, a graft that contains 2 and 3 hairs in the very front of the hairline would cause a "pluggy" look. Likewise, coarse instead of fine 1-hair grafts placed in the hairline would also make the result look unnatural and "pluggy."
3. A proper depth for graft placement is approximately 1mm above the surrounding scalp. If the graft is placed into a site half its length and is therefore protruding from the site, it may dry out and result in poor growth. Conversely, if a graft is placed too deep, it may cause pitting, an intradermal cyst; and if buried very deep into a site, it may cause an ingrown hair.
4. Each hair follicle possesses a natural curl, which the assistant should identify and properly orient in the site during graft placement. Following a natural pattern, hair curl in the male hairline faces forward, in the temples down and back, and in the vertex it swirls. If the hair curl points sideways or upwards in the hairline (instead of forward and downward), the hair will grow haphazardly in splayed out directions thus exposing the scalp, causing an unnatural cowlick. The result would lack visual density and the patient wound have difficulty with hair styling.✧

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NEW! We have instituted an Online Buyer's Guide for members' use on the ISHRS website. It includes the names and contact information of many hair restoration surgery vendors—past exhibitors, advertisers, and corporate supporters of the ISHRS.

Click on the Members Only section at www.ishrs.org. The Online Buyer's Guide is listed under "What's New".

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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.

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David Perez-Meza, M.D., Co-Chairman
Marco Barusco, M.D., Program Coordinator

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Dr. Matt L. Leavitt, D.O.

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Upcoming Events

Date(s)	Event/Venue	Sponsoring Organization(s)	Contact Information
Academic Year 2009–2010	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 2010	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*
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*
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	Damkerng Pathomvanich, MD *path_d@hotmail.com*
July 23-25, 2010	2nd Annual Hair Restoration Surgery Cadaver Workshop *St. Louis, Missouri, USA*	Practical Anatomy & Surgical Education, Center for Anatomical Science and Education, Saint Louis University School of Medicine *http://pa.slu.edu* in collaboration with the International Society of Hair Restoration Surgery	*http://pa.slu.edu*
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*
October 20-24, 2010	18th Annual Scientific Meeting of the International Society of Hair Restoration Surgery *Boston, Massachusetts, USA*	International Society of Hair Restoration Surgery *www.ISHRS.org/18thAnnualMeeting.html*	Tel: 630-262-5399 Fax: 630-262-1520
February 24-25, 2011	16th Annual Scientific Meeting and Live Surgery Workshop *Okinawa, Japan*	Japan Society of Clinical Hair Restoration (JSCHR) *www.jschr.org* Hosted by Akio Sato, MD	Tel: +81-3-5351-0309 Fax: +81-3-5351-1395 *drsato@crux.ocn.ne.jp*

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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