HAIR TRANSPLANT forum INTERNATIONAL

INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

Volume 20, Number 4
July/August 2010

COLUMNS



FEATURE ARTICLES





# Our hats off to you, as we bid you a fond adieu…

## Cheryl Pomerantz, RN 1949–2010

Those of us who knew her were shocked and saddened to hear of the sudden death of Cheryl Pomerantz, RN on July 3, 2010. She and her husband Marc were both Foundation Members of the ISHRS in 1993 and they took an active role in the formation of our Society.

With her homemade hats and feather boa, Cheryl always seemed larger than life and was great company. She was editor of the *Forum*'s Surgical Assistants Corner from 1998 to 2001 and again in 2004. In addition, she organized the Surgical Assistants Program at several meetings. I was delighted when she received the very first Assistants Award in 2003. She was still serving on the Awards Committee at the time of her death.

Always happy and utterly fearless, Cheryl would tackle any challenge and usually be successful. We will miss her greatly and I am sure that fellow ISHRS members will join me in offering heartfelt condolences to husband Marc and Cheryl's son, Justin.

*Richard Shiell, MBBS*

I met Cheryl ten years ago thanks to the wonderful "family" of the ISHRS. We hit it off instantly as neither of us takes ourselves too seriously and enjoy having fun to the point that others may see it as ridiculous. Our meetings through the years have been peppered with amazing hats, feather boas, singing and dancing, and all in good fun.

Marc, you have been blessed with a wonderful and creative wife, not to men-

⇨ page 114

**Hair Transplant Forum International**
**Volume 20, Number 4**

*Hair Transplant Forum International* is published bi-monthly by the International Society of Hair Restoration Surgery, 303 West State Street, Geneva, IL 60134. First class postage paid at Chicago, IL and additional mailing offices. POSTMASTER: Send address changes to *Hair Transplant Forum International*, International Society of Hair Restoration Surgery, 303 West State Street, Geneva, IL 60134. Telephone: 630-262-5399, U.S. Domestic Toll Free: 800-444-2737; Fax: 630-262-1520.





# President's Message

Edwin S. Epstein, MD *Virginia Beach, Virginia* esehairmd@gmail.com

Who is qualified to perform scalp surgery? The knee-jerk and obvious answer seems simple: the physician, of course. Can and should scalp procedure be delegated to surgical assistants? The legal answer resides within interpretation of local regulations, but the philosophical decision rests within each physician's practice. So why do these seemingly simple questions evoke so many emotional responses?

First, we should define scalp surgery. A scalp reduction or flap procedure easily falls into the category, and so should strip harvesting. But what about a 4mm punch biopsy, and does that differ from a 0.7-1.0mm punch biopsy? Is removing tissue, that is, extracting a follicular unit, surgery? How about simply cutting or incising the scalp? Should we consider incision sites in recipient areas scalp surgery? Does this differ from the phlebotomist's needle insertion to draw blood?

The ISHRS is at the forefront of hair restoration surgery and should set the guidelines and standards for best practice. In May 2010 I convened an ad hoc committee composed of past presidents with the directive to develop a position statement as to who should perform follicular unit extraction. Dr. Dow Stough headed the committee, which also included Drs. Robert Leonard, Robert Haber, Tony Mangubat, and Paul Rose. The Board of Governors has accepted the following position statement:

"The position of the International Society of Hair Restoration Surgery is that any tissue removal from the scalp or body, by any means, must be performed by a licensed physician in the field of medicine. Physicians who perform hair restoration surgery must possess the education, training, and current competency in the field of hair restoration surgery. It is beyond the scope of practice for non-licensed personnel to perform surgery. Surgical removal of tissue by non-licensed medical personnel may be considered practicing medicine without a license by state, federal, or local governing boards of medicine. The Society supports the scope of practice of medicine as defined by a physician's state, country, or local legally governing board of medicine."

Local medical boards review most regulations, and changes are made in response to complaints by patients or serious surgical complications. Most regulations that address whether physicians may delegate procedural responsibility to surgical assistants, licensed or otherwise, are vague, leaving both the decision and the potential risks to one's medical license to the physician. The ISHRS leadership contends that this position statement provides clarity for our members and, ultimately, for their patients.

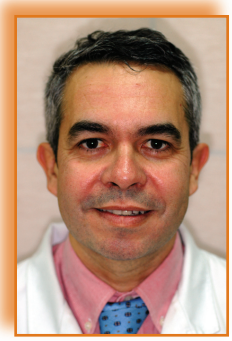
On a lighter note, I recently returned from the Italian Hair Society meeting in Capri, Italy, and would like to congratulate Dr. Piero Tesauro and his staff for a well-run and excellent academic congress. Boston is almost here and Dr. Paul McAndrews and the entire committee have put together a great program. Please make plans to attend!

*Edwin S. Epstein, MD*

# Co-editors' Messages

Paco Jimenez, MD *Las Palmas, Spain*
*jimenezeditor@clinicadelpelo.com*

Bernard Nusbaum, MD *Coral Gables, Florida*
*drnusbaum@yahoo.com*



A new model for the pathogenesis of cicatricial alopecia has emerged in which the main protagonist is the lipid metabolism of the pilosebaceous unit. As strange as it may sound, a recent article discovered that genes required for lipid metabolism and peroxisome biogenesis are decreased in patients with lichen planopilaris (LPP). Specifically, the initial trigger of inflammation in LPP could be an abnormal functioning of the peroxisome proliferatior-activated receptor gamma (PPAR-gamma). A loss of PPAR-gamma function leads to a decreased peroxisome biogenesis and to an aberrant lipid metabolism in the sebaceous gland, a toxic buildup of lipids, and a subsequent inflammatory response. As a result, the dense inflammatory infiltrate would destroy the portion of the follicle where stem cells are located, resulting in a permanent scarring alopecia.

It is encouraging to note that pioglitazone hydrochloride, 15 mg/d orally, a medication used in the treatment of type 2 diabetes mellitus that increases the activity of PPAR-gamma, has shown clinical improvement in LPP according to one recent publication (*Arch Dermatol.* 2009; 145:1363).

After reading this paper, I wondered whether this medication would work in frontal fibrosing alopecia (FFA), a very interesting disease that shares a similar or identical histopathologic pattern with LPP. At least in my area (Canary Islands), the most common cicatricial alopecia that I see in my practice nowadays is FFA. It has such a typical clinical pattern that most of the time a diagnosis can be made while the patient is entering through the consultation door. This

⇨ page 112

The ISHRS is synonymous with education, networking, and the industry of hair restoration, but the Society would not exist without people like Cheryl Pomerantz, RN whose recent passing we mourn, and whose friendship and dedication are remembered in this issue's cover story. While it is difficult to discuss the scientific articles that comprise this issue in the same message that remembers Cheryl's influence on our Society, it seems proper, because Cheryl stood for improving patient care and providing aesthetic and safe hair restoration surgery—goals that are advanced by this *Forum* issue.

One of the hot topics in our field is that of the "long hair" transplantation technique and, in this issue, Dr. Crisóstomo presents his quantitative comparison of the key components of the hair restoration procedure comparing the long hair technique to the classic shaved hair technique. In an interesting note from the foremost expert on this technique, Dr. Marcelo Pitchon comments on the technical aspects as well as the subjective, artistic advantages that are provided by this technique for both the patient and the surgeon.

While FUE continues to evolve, Dr. Akaki Tsilosani presents his work on expanding the number of follicular units transplanted in one session by combining strip excision and FUE. He presents a novel concept comparing strip wound closure tension before and after FUE is performed above and below the linear incision. In a format that Dr. Jimenez and I have tried to implement for the *Forum*, we have elicited an editorial comment from one of the experts in the field, Dr.

⇨ page 112

## Editorial Guidelines for Submission and Acceptance of Articles for the *Forum* Publication:

1. Articles should be written with the intent of sharing scientific information with the purpose of progressing the art and science of hair restoration and benefiting patient outcomes.
2. If results are presented, the medical regimen or surgical techniques that were used to obtain the results should be disclosed in detail.
3. Articles submitted with the sole purpose of promotion or marketing will not be accepted.
4. Authors should acknowledge all funding sources that supported their work as well as any relevant corporate affiliation.
5. Trademarked names should not be used to refer to devices or techniques, when possible.
6. Although we encourage submission of articles that may only contain the author's opinion for the purpose of stimulating thought, the editors may present such articles to colleagues who are experts in the particular area in question, for the purpose of obtaining rebuttal opinions to be published alongside the original article. Occasionally, a manuscript might be sent to an external reviewer, who will judge the manuscript in a blinded fashion to make recommendations about its acceptance, further revision, or rejection.
7. Once the manuscript is accepted, it will be published as soon as possible, depending on space availability.
8. All manuscripts should be submitted to both **drnusbaum@yahoo.com** and **jimenezeditor@clinicadelpelo.com.**
9. A completed Author Authorization and Release form—sent as a Word document (not a fax)—must accompany your submission. The form can be obtained in the Members Only section of the Society website at www.ishrs.org.
10. All photos and figures referred to in your article should be sent as separate attachments in JPEG or TIFF format. Be sure to attach your files to the email. Do ***NOT*** embed your files in the email or in the document itself (other than to show placement within the article).
11. We *CANNOT* accept photos taken on cell phones.

*Submission deadlines:*
August 5 for September/October 2010 issue
October 5 for November/December 2010 issue
December 5 for January/February 2011 issue

## Dr. Jimenez's Message

⇦ from page 111

disease is very frustrating for women affected by it, since most medical therapies do not work and hair transplantation does not seem to be an option because it does not stop the progression of the disease and the chance for long-term auto-destruction of the implanted grafts is very high. So why does this occur almost exclusively in women, most of them postmenopausal and older than 55 years old, and why we are seeing so many cases now when 20 years ago this disease had not even been described? Could it be that we are facing a new toxic, environmental disease? These are but a few of the unsolved questions for this mysterious disease.

*Paco Jimenez, MD*

## Dr. Nusbaum's Message

⇦ from page 111

Robert True, which I think is certainly thought-provoking and which I know you will enjoy reading. We are fortunate to have received yet another article from Dr. Damkerng Pathomvanich's group in which lead author Dr. Theresa Cacas and associates present their "quick reference" method for identifying what I consider the most important anatomical structure in hair restoration: the location of the occipital neurovascular bundle. In "How I Do It," Dr. Michael Beehner presents an interesting technique for avoiding the nemesis area for strip excision: the mastoid region.

I hope you find this issue to be informative and enjoyable.

*Bernard Nusbaum, MD*

# Notes from the Editor Emeritus

Russell Knudsen, MBBS *Sydney, Australia* drknudsen@hair-surgeon.com

Doesn't it still strike you as ironic that, in 2010, while achieving the best, most natural hair transplant (HT) results via FU grafting that have ever been seen, we, as a medical specialty field, still attract such low regard in the online blogosphere?

Why is this so? I will contend that a significant factor is that many practitioners in our field confuse the product with the service.

The product in our field is the FU graft (produced by either strip excision or FUE).

The service is the design and execution of the movement of the FU grafts from the donor to the recipient areas to achieve the patient's goals in the most natural manner.

When you market a product, the consumers (our patients) expect uniform quality of the branded product, wherever the product is purchased. This allows the consumer to judge a purchase decision around pricing. A GE toaster is still a GE toaster wherever you make the purchase.

When you market a service, the consumer is critically aware it matters who is providing the service as to expectations regarding the quality of the service. Consumers accept that differential pricing is appropriate and will make decisions based on a value judgment of the service offered.

So, how does this impact on the HT industry? It has long been my view that competitive advertising utilizing pricing is self-defeating as it persuades the potential consumer (patient) that judging the product (FUT/FUE) by pricing alone is appropriate, as the service is equivalent among different practitioners. Competition in the marketplace is generally good as it helps lift standards. Competition that belittles the service (the "race to the bottom" of ever cheaper advertised graft prices) is likely to lower standards as doctors and clinics seek ways to make the diminishing financial returns remain profitable.

This, in some cases, means that the doctor's involvement in the procedure is minimized and the assistants input is maximized.

I believe successful marketing revolves around perceived value, which can be seen as a combination of the product and the service. Perceived value, while influenced by pricing, isn't solely decided by pricing.

What influences perceived value? A combination of factors: choice of surgeon (or clinic) based on reputation, experience, personal involvement in the operation, demonstrated outcomes in other patients, etc. The analogy I prefer is that performing a hair transplant is like hand-building a car. It might be cheaper to mass-produce the "car" (the Model T Ford production line approach), but the perceived value of the hand-built vehicle (Rolls Royce, Ferrari, Lamborghini, Aston Martin, etc.) justifies the extra expense as it is recognized as a luxury service. You can still price as you wish, but you are not selling to the cheapest-option sector of the marketplace. Let's remember that every outcome of our procedure is unique. There is no general equivalence as to the result as it depends upon both the design and the execution of the procedure.

If we take these factors into consideration, how do we increase the perceived value of our product/service?

First, we doctors must reclaim the operation. Stick-and-place by assistants can have a role but, for most of us, we need to be seen to be performing the operation. For purely philosophical reasons, I am the only person allowed to cut the patient. It is then MY operation and I will take FULL responsibility for the result.

Clinics that pretend that a doctor oversees the procedure while having little to no role do us a disservice. As our president, Dr. Ed Epstein, discusses in his *Forum* column, the oncoming mechanization of FUE harvesting might make it attractive for doctors to divest the harvesting to their staff or, far worse, encourage non-medical "independent contractors" to market their FUE services to largely uninvolved doctors seeking a quick secondary source of income.

Success in our field is not solely based upon quality outcomes. It is also based upon patient satisfaction with our quality outcomes. For this, we need to develop good relationships with our patients that will lead to trust and respect.

If we don't respect ourselves and our procedure, how can we expect prospective patients to do so?✧

tion hard working and dedicated to the development of the Surgical Assistants Program.

As Chair of the Committee on developing a Staff Training Program for doctors, which has been a year in completion, and in which Cheryl was an instigator, it saddened me to learn of her death on the same day as the program was finalised.

Cheryl will live on in my heart, although she will be greatly missed.

Marc, may it comfort you to know that my friendship is always there. All I can offer you is tender compassion and understanding.

Saying goodbye is the hardest thing I've ever had to do. I'll miss you Cheryl, forever.

*Jennifer Martinick, MBBS*

There are no words that can accurately depict Cheryl's dedication and influence on the ISHRS. She was selfless in her efforts to build awareness of the importance of assistants in the field and develop meaningful educational forums to raise our standards. From a personal perspective, Cheryl was a genuine, warm and caring friend. I will miss her.

*Matt Leavitt, DO*

It was with profound sadness to learn from Marc of Cheryl's sudden death. It truly was a shock not only to me, but to our entire profession.

There are three things that come to mind when I think of this lovely lady. First, were the many talks we had about how we each felt that the profession of medicine has become so less professional. We discussed (and lamented) how, especially in our field, that underhanded business practices and unethical behavior have too often overshadowed the doctor-patient relationship. We talked about how doctors—colleagues—so often denigrated one another simply to "make a sale" of patients who visited various offices in their due diligence in deciding who to choose to perform their procedure. We usually talked about too much of taking the low road instead of the high road….

Secondly, I have such high respect for Cheryl's continuous hard work to make our procedures more safe, efficient, and comfortable for our patients. She taught hair transplant assistants and physicians alike on these topics. In addition, because I sincerely love our Society, I always did and continue to thank her for all the work she had done to make the ISHRS what it is today. For this I am eternally grateful.

Lastly, what a stylish diva Cheryl was! She provided panache and fun and elegance to all of our meetings! Her signature headgear will never be forgotten. As a husband, I also observed how very much she loved Marc—how fortunate he has been to have her as a partner and wife.

HATS OFF TO YOU, CHERYL! May your memory be eternal!

*Robert Leonard, DO*

Truly a shock. She was a gift of God to all of us. Always something to contribute, and willing to help in any way she could. We will all miss her.

*Carlos J. Puig, DO*

A few years ago I had the pleasure of working with Cheryl as a member of a task force chaired by Carlos Puig, in the early phases of designing the core curriculum for the CD-based assistants program. My participation was brief as I left to take on the role of Scientific Chairman for our annual meeting. Truthfully, I really wasn't needed since I found in our first conversations she had already written and organized comprehensively all the core points that I would have recommended! In particular, I recall the conversations Cheryl and I had about OR etiquette and staff professionalism. I was amazed to learn we abhorred similar stories from patients who recounted their experiences with some clinics where operating staff didn't seem to understand that even though hair restoration is elective, cosmetic surgery, it was surgery, and rules of operating room etiquette still applied.

It was clear to me that Cheryl and I shared common values for rules of safety and appropriate behavior when it came to caring for patients. It was easy for me to see that she was an "old school" nurse, and if you don't know what that means, my best description is, it's like having a second "mom" in the OR who takes care of you (the surgeon) as well as she does the patient—determined to limit frustration, and provide maximal organization so the surgeon never has to go looking for tools or medication etc…. I knew from our conversations that she would run a seamless operating room, and could discern that "responsibility" was her coat of arms. We even spoke a little bit about how she met Marc as a surgical nurse, when he was still a general surgeon. Nurses like Cheryl are not easy to find today, and I knew Dr. Marc Pomerantz was a lucky surgeon to have her. But as we know, she was much more than an OR nurse for Marc, and I am profoundly saddened for his loss. I admired her determination to make a difference in the education of assistant staff, I admired her flair and sense of self…only Cheryl could pull off those hats and look fabulous in them! I will very much miss seeing her at our meetings, and miss the intelligence and leadership she showed for excellence in the education and training of nurses and assistants. I am deeply saddened that she will not be present any longer at our meetings, but her contribution will live on in all that she has done to promote quality education and patient care.

*Sharon A. Keene, MD*

Cheryl was active with her husband, Marc, in the ISHRS even before the by-laws were written and approved. When the by-laws included an Assistants Ancillary she took action and, with the help of her friends, organized the first meetings. For a decade or more the highly successful meetings of the assistants group were largely the efforts of Cheryl. She represented the assistants at the Board of Governors meetings and strongly championed their cause.

The ISHRS meant a lot to Cheryl and Cheryl meant a lot to the ISHRS. We will deeply miss her.

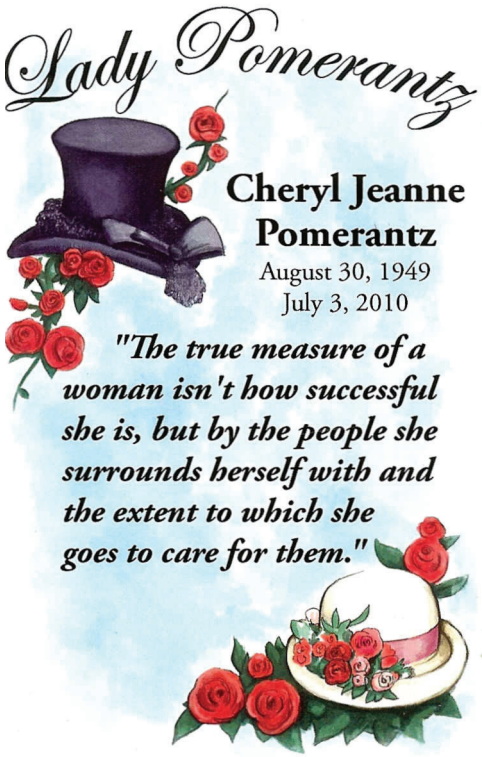
*Paul Straub, MD*

I felt so sad to hear that Cheryl had passed away. I will miss her but her spirit may be with us in the assistant workshop in Boston.

*Damkerng Pathomvanich, MD*

Cheryl always had a big presence when she entered a room, as demonstrated from her big voice, big hats, big ideas that she wasn't timid to share, and her big heart. I got to know Cheryl when I was Chair of the Washington meeting and she was the Surgical Assistants Chair. Cheryl always had novel ideas on ways of teaching the assistants, and getting people involved, from auctions to cookbooks. Cheryl always stood up for those she worked with and always spoke her mind. She deserved and was given a lot of respect from those around her. I will miss Cheryl, from her grand entrances to her grand concern for others.

*Paul Cotterill, MD*




In 1996, I didn't know Cheryl Pomerantz very well. She wore crazy hats, and I assumed she was just an eccentric lady. I was the program chairman for the ISHRS meeting in Barcelona, and the program included a live surgery session that I was expecting to be a highlight. The evening before the session, I met with several individuals involved, and Cheryl joined us, uninvited. She proceeded to ask me question after question. How was I prepared for various scenarios? What steps had I taken to assure safety? Questions about instruments, traffic flow, and more. As she asked these questions, my heart sank, as my responses were ill prepared, and I saw disaster looming ahead. However, after identifying many deficiencies, Cheryl then cheerfully offered to solve them, and off she went. In less than 12 hours, she managed to reorganize the entire live surgery program, and it ran as smooth as silk. From that moment on, Cheryl was my heroine. It's easy to find fault in a plan. It's not all that difficult to know how to solve those faults. But it's quite extraordinary to actually volunteer to solve a myriad of problems, in a foreign country, at a moment's notice, and succeed. And why did she do it? Patient care. Her involvement wasn't about making the doctor's experience better, but rather about making sure that nothing diminished the care that the patients were to receive. And in the fourteen years since that meeting, her focus on and devotion to the patient never wavered. I miss her already.

*Bob Haber, MD*

I have always thought of Cheryl Pomerantz as "larger than life," so it is difficult to comprehend that she is no longer with us. Cheryl's loyalty and passion for our organization knew no bounds. She was the glue that kept our Surgical Assistants Program together as we struggled to become established and recognized.

Cheryl was committed to welcoming and teaching newcomers and "rounding up" those of us who had been around for awhile to help her with her many projects.

Cheryl had a wonderfully creative side to her life and she loved to surprise us with her latest hats and beautiful gowns; all of which she designed and sewed herself.

We all loved Cheryl and recognized her many contributions.

We all mourn together across the miles that separate us.

*Marilynne Gillespie, RN*

I was shocked when I learned of Cheryl's unexpected death. She passed away peacefully in her sleep over the Independence Day holiday weekend here in the U.S. As her son Justin said at the funeral, this was fitting for Cheryl's death to be timed to a celebration, because she was a celebration of life. For those who knew her, Cheryl was smart, outspoken, passionate about her field, and very energetic. She liked things done her way and let those of us who worked with her know it. (smile) Cheryl was my friend, and I felt a special closeness with her because we are both from the Chicagoland area. Cheryl made an entrance and could not be missed at the annual Galas. I was looking forward to seeing her again at the Boston meeting. Now we will only have her memory. Rest in peace, Cheryl. We will miss you very much.

*Victoria Ceh, MPA*

When I first joined the ISHRS team as designer/editor of the *Forum*, I had the pleasure of communicating with Cheryl, then the assistants editor, as we looked to build up the Surgical Assistants Corner. When the phone would ring and Cheryl was on the other line, my husband would hand me the phone, grab a book, and leave the room—he knew it would be a while.

Cheryl was a unique personality that grabbed you in. I couldn't help but admire her intelligence, passion, and dedication, which shown through with every conversation.

Her sparkle will truly be missed.

*Cheryl Duckler*