HAIR TRANSPLANT forum INTERNATIONAL

INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

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Inside this issue

Candidacy of females for hair transplantation

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Last year, in an issue of O, The Oprah Magazine, one of our esteemed colleagues was quoted as saying that *"only about 20% of female patients with thinning hair are candidates"* for hair transplantation. If I had been asked, I would have said that of the women that I see in consultation, only 20% are not candidates and, at the very least, a majority are.[1] More specifically, at most, only 20% of the women that I see do not have sufficient acceptable donor tissue for at least one small session of 800-1,200 FUs. Acceptable donor is hair that is judged to be permanent and that lies in the area of scalp considered to be the donor area for males. Although many of the women we see have more than one such session available in their donor area, if even one procedure is carried out in a well-chosen, cosmetically important area, they can achieve a very satisfying cosmetic result (Figure 1).

There is good reason to believe that this statement in O Magazine could be understood (directly and indirectly) by millions of women with female pattern hair loss (FPHL) as a consensus view of hair restoration surgeons (HRS). What is in fact the consensus of a sampling of expert hair restoration surgeons on this subject? I thought it was important to try to clarify the answer to that question by sending an email to a large group of some of our most experienced colleagues. Each was asked: What percentage of women you see with FPHL has at least enough good donor tissue for one small session of 800-1,000 FUs?

Figure 1. *A:* A 52-year-old female patient before hair transplanting in a frontal midline area with low hair density. *B:* 7 years after a hair transplant consisting of 843 FU and 113 DFU (a total of 1,069 FU). The patient was being seen for possible transplanting posterior to the first recipient area. *C:* Photo taken at the same time as B, with the hair combed back for critical evaluation. A little hair placed properly and with good hair survival goes a long way cosmetically. The fear of losing transplanted hair is also misplaced if the donor area has been appropriately chosen.

Out of the 28 physicians who responded to the question, the following was found: 6 thought that 20% to 25% (or fewer) women with FPHL they see are candidates; 2 thought approximately 35%; 7 thought 40 to 50%; 5 thought 60 to 65%; 8 thought 70 to 80% (or more). Included in the lowest percentage group were Drs. Bernstein, Rassman, Wolf, Epstein, Wong and Stough. The 8 members of the group that answered *70% or more* included Drs. Limmer, Beehner, Perez-Meza, Leonard, Cooley, Mayer, Jerry Shapiro, and the presenter. Some of the reasoning of members of each of the groups is included below.

It was unanimously agreed that all patients (incidentally men as well as women) should be advised of the likelihood of loss of *some* transplanted hair over the years. It was, of course, universally agreed upon that none of the respondents would operate on somebody whose donor area might be satisfactory today but he/she thought would most likely be inadequate in the future. Because of this reality, the most cautious of us would pick the lowest percentages of acceptable candidates. Unfortunately, this group would probably never know whether their pessimistic prognosis was valid or not because they would almost certainly never again see a large majority of their rejected patients. On the other hand, surgeons at the optimistic prognostic end of the acceptable scale would be very likely to see their patients again—especially if they were dissatisfied—and would therefore be more appropriately informed as to whether or not they should change their practice philosophy.

The source of patients for different offices is different and this is likely to affect the percentage of "acceptable" patients seen. For example, those doctors whose practice referral source is primarily the Internet or other promotional venues are more likely to see a higher percentage of unacceptable individuals than those surgeons whose patients are primarily referred by knowledgeable prior patients, physicians and hairstylists. Moreover, the entire group agreed, for a variety of reasons, that not everyone who is a candidate should or would proceed because of

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President's Message

Jerry E. Cooley, MD *Charlotte, North Carolina, USA* jcooley@haircenter.com

This past January 2011, the leadership of the ISHRS met to conduct a strategic planning meeting, something we do every three years to plan our future. At this meeting, we formulated new **Mission** and **Vision Statements** and I would like to share these with you in this column. The **Mission Statement** describes what business we are in now, while the **Vision Statement** refers to where we hope to be in the future and serves as a guiding principle or "north star" if you will.

The mission of the ISHRS, according to our new statement, is: *To achieve excellence in patient outcomes by promoting member education, international collegiality, research, ethics, and public awareness.* A great deal of effort went in to deciding what to include and what to exclude. As this statement makes clear, our top priority is our patients. Our methods to achieve excellent outcomes includes first and foremost, **member education**, meaning all aspects of hair restoration surgery from beginning to advanced. The annual scientific meeting is our largest educational offering, but we also put significant time and energy into regional workshops, the *Hair Transplant Forum,* Internet webinars, and other audiovisual materials.

Our second purpose, **international collegiality**, refers not only to the makeup of our Society but also the conscious effort on our part to promote relations between members from different countries and regions of the world. At our annual meeting, a convenient venue exists to meet, socialize, and network with physicians in this field from all parts of the globe. By composing boards and committees with members from different countries, we ensure that our leadership reflects our membership. We are also putting effort into translating our website into other languages.

The best way for us to achieve our vision is by doing our mission, over and over, every day, and to the best of our abilities.

As with most medical societies, we promote **research** as an integral part of who we are. Nothing stays the same and we facilitate scientific, evidence-based research activities within the realm of hair restoration surgery to ensure continued evolution of our field. We have since our inception provided research grants to worthy projects and recently I participated in a webinar on biostatistics to improve the quality of the research that we do fund. Research findings are discussed at meetings and in the *Hair Transplant Forum* and *Dermatologic Surgery.*

This brings us to **ethics**. In the medical realm, this refers to how we interact with our patients and our colleagues. By putting our patients' interests above all else, and treating our colleagues as we would want to be treated, we become known as moral people and we safeguard the reputation of our specialty and the ISHRS. Let's face it, hair restoration surgery has an imperfect past in terms of ethics, when financial concerns were placed above the best interests of the patient. We must keep ethics on the front burner because we all need frequent reminders.

Finally, we get to **public awareness**. As a non-profit society, we have a duty to educate the public about hair loss and what treatments and procedures are available. This is an end in itself and is not designed primarily to drive patients into our offices. As we educate each other at the professional level, we in turn educate the public. And this brings us to our new **Vision Statement**: *To establish the ISHRS as the leading unbiased authority in hair restoration surgery.* In my opinion, the best way for us to achieve our vision is by doing our mission, over and over, every day, and to the best of our abilities.◆

Co-editors' Messages

Nilofer P. Farjo, MBChB *Manchester, United Kingdom* editors@ISHRS.org

In this issue we have discussion on some very important topics. There are several that cover issues to do with female hair loss. Dr. Walter Unger's thought-provoking article and the replies by experts show the diversity of opinions that exist in dealing with women's hair loss. But it also points out how, no matter what our experience we, can sometimes get it wrong. The main thing to keep in mind is that we should be getting it right the majority of the time. We have guidelines but there are always exceptions. There are two other articles by eminent surgeons looking at the issues of diagnosis of female hair loss, an often complicated issue that is not as straightforward as in men. Dr. Paul McAndrews shares with us his hair loss algorithm and Dr. Edwin Suddleson gives his advice on the treatment for polycystic ovarian syndrome. Dr. Sharon Keene's Cyberchat touches on some dietary issues that may lead to iron deficiency, a condition we mainly see in women.

Emergency preparedness for high-risk cardiac patients is discussed in Dr. Kuniyoshi Yagyu's article. As we see more elderly patients seeking hair restoration, he reminds us of the vigilance required in dealing with this age group and the management required in treating these patients. Many of us would turn these patients away but Dr. Yagyu gives us the pointers to manage these high risks in a safe way. As a former cardiac surgeon, Dr. Yagyu has the benefit of experience with cardiac management that many of us do not have, and therefore we may not feel the same level of confidence. Be sure to attend Dr. Yagyu's session at the annual meeting in Alaska where he will speak on some of these cardiac issues.

Genetic research into AGA is an exciting area of study being conducted in several centers around the world. In this issue, Prof. Rodney Sinclair and his group discuss the concept of epigenetics and how this may relate to the genetics of hair loss in male pattern hair loss by DNA-methylation.◆

William H. Reed, MD *La Jolla, California, USA* editors@ISHRS.org

Improving the quality of what we do is what the ISHRS is all about. It attempts to do this by providing venues for fellow surgeons to meet to exchange ideas and to develop friendships. In addition to the meetings that it sponsors throughout the year, the ISHRS offers a Fellowship Training Program that has turned out some of the best surgeons in our field. However, the Fellowship, since it offers no remuneration and requires the fellow to live where the Fellowship is offered, fulfills the needs of relatively few physicians. It is with these limitations in mind that two new ISHRS efforts are useful: Listserv+ and the Extended Newcomers Program at the upcoming Anchorage meeting.

As described by the ISHRS, Listserv+ "is a convenient way to contact more than one person at a time" and "the topics and the threads will be archived on the ISHRS website for future reference." Listserv+ discussion groups are open to members only. This can be a great format for sharing opinions and asking questions on a wide variety of subjects relating to hair restoration. It should be live about the time of this issue's coming to print and can be accessed via the "Members Home Page" at ISHRS.org. LISTSERV+ URL: http://www.ishrs.org/members/member-index.php#

The Listserv+ is a good forum for discussions resulting from the second ISHRS effort to educate: the Extended Newcomers Program. This program enables newcomers to be paired with experienced surgeons at the meeting in Anchorage with the possibility of extending their relationship beyond the meeting for two years. (See page 135 for more details.)

Those of you who have read my earlier editorials know that I believe diversity is an important element in the remarkable progress of our field over the past 15 years. Large organizations such as Bosley and, in days past, MHR make and have made critical contributions to this progress. Just as critical, however, are the contributions, including the very formation of the ISHRS itself, of the individual surgeon. While the large organizations train their own well, these two new programs from the ISHRS offer the germ that can make significant contributions to the training of the individual practitioner whose life circumstances prevent him or her taking advantage of the Fellowship Program.

Unlike "Top Down" methods of development where the executive level dictates direction, how these germs of "Bottom Up" organization offered by the ISHRS will grow to fruition are less well defined here at their outset. Nevertheless, their possibilities are exciting. The Listserv+ forum is an opportunity waiting to discuss a wide range of topics. Individuals participating in a discussion can share their opinions as well as write emails to authorities who may not have begun participating to ask them to join the discussion to share their expertise to the whole group of participants.

Although not its main purpose, Listserv+, by its very existence, will be an informal marketplace where, for example, surgeons can ask for or offer services such as providing assistance in getting a newcomer's practice started. I know how important that was to me when the late Dr. Jim Arnold and his capable technicians visited to help me get started. What services are offered matters not as much as the existence of the Listserv+ forum, which allows our needs to be defined and addressed.

The ISHRS, arguably threatened by its success and age alone

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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 editors@ISHRS.org.
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.
12. Please include a contact email address to be published with your article.

Submission deadlines:
August 5 for September/October 2011 issue
October 5 for November/December 2011 issue

INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

Vision: To establish the ISHRS as the leading unbiased authority in hair restoration surgery.

Mission: To achieve excellence in patient outcomes by promoting member education, international collegiality, research, ethics, and public awareness.

Reed Message

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of becoming "An Institution" (see Dr. Paul Straub's informative historical review in last month's Controversies), revitalizes itself with ideas such as Listserv+ and the Expanded Newcomer Program. It balances its "Top Down" Fellowship Program now with these two new "Bottom Up" programs. With these ideas the ISHRS has provided us the opportunity. Keeping our profession vital with diversity from the "Top" as well as the "Bottom," from the Big and Small, from the Corporate and the Individual, is up to its members. I encourage you to be active in these new programs from the ISHRS. Register for the Extended Newcomers Program when you register for the Anchorage meeting and watch for, participate in, and enjoy the Listserv+ format for enhancing our knowledge and collegiality.◆

Update on proposition of regulations on who can perform HTs in Europe

Jean Devroye, MD, ISHRS Representative to CEN/TC 403, *Brussels, Belgium* office@drdevroye.com

In Europe, the practice of hair transplant surgery is in danger. Actually, for one and a half years, a "normalization" group has been created under the aegis of European aesthetic surgeons. The aim of this group is to define precisely, on the European level, the general rules that must apply to the practice of medicine and aesthetic surgery. The practice of hair transplants is, of course, tackled, too.

The main problem is to define the competences. In the current project, only the general surgeons, the maxillofacial surgeons, and the aesthetic surgeons can practice micro hair transplants. Moreover, there is not a single mention about the difference between FUT and FUE. It is logical that flap surgeries and scalp reductions can be performed only by surgeons, but it is absurd to forbid non-surgeons from performing FUT or FUE procedures.

On the European level, the directive is managed by the CEN (Comité Européen de Normalisation) and by national organizations of normalization. The secretary of the European Committee named CEN403 is Dr. Grün based in Austria. The different representatives meet with each other periodically to discuss the amendments to the text. The last meeting took place in Austria, Vienna, at the end of May 2011. The next one will take place in Florence, Italy, on the 23rd of September 2011.

The national groups of the CEN403 have met for the past year and a half. At the beginning, CEN403 was created by aesthetic surgeons. This explains that most of the positions in the different national mirror committees of each European country are held by them.

Commissions work in this way: During these Europeans CEN meetings, each European country is represented by one to three delegates chosen among the members of the entire commission. One of them only can speak and vote on behalf of the whole commission: he is supposed to reflect the opinion of all the members of the mirror committees. Those national commissions are created in each European country by the national organizations, which are in charge of the norms; for example, the AFNOR in France, the Din in Germany, the UNI in Italy, the BSI in England, and the AENOR in Spain

In two years, the directive would be definitively approved by the CEN. At this moment, the directive, which is normally non-restrictive and voluntary, would be available for all states. It will probably happen that, despite the appeasement given by the members of the CEN, this norm (which will be associated to a European directive) will become a law.

In the past, we have seen that it is easier for a state to refer to a European directive instead of wasting energy and time to create its own norms.

Since May 2011, what have we already done?

On one hand, a letter was sent on behalf of the ISHRS to Dr. Grün, which led to the ISHRS being accepted as a liaison society "observer."

I am the official representative of the ISHRS among the CEN, thus, thanks to this, we can have access to all documents in relation to the CEN403 directive and also can attend the CEN international meetings.

On the other hand, I am registered in the "mirror commission" of the Belgian branch of the CEN, represented by the NBE in Belgium. I have had the opportunity to better understand the functioning and the history of this commission.

It would be a good idea to have an ISHRS hair transplant member in each national commission. The member would have to attend the meetings of the national commission a few times a year.

It would also be good idea to get together to set up a common line of arguments and propose concrete solutions regarding the qualification of the doctors who practice hair transplants.

I invite every person interested in this topic to contact me as soon as possible.◆

Candidacy of females

from front page

information they should *always* be given about the procedure, the postoperative sequelae—especially the temporary recipient area hair loss that occurs in approximately 50% of women—and their personal likely outcomes. For example, in a subsequent review I conducted on 471 consultations I had with women from 2003 to 2009, who I thought could proceed with surgery, only 36% did so. In comparison, more than 60% of men I have "accepted" in the last year have proceeded with surgery. (This is probably a higher percentage than in most practices because most of my patients come to me via prior patient, physician or hairstylist referrals.)

A surgeon's view of the likely success of a hair transplant will quite reasonably always be affected by his or her prior patient results. Some of the experts in the 20-25% group said that minimal hair density gain was the rule rather than the exception in the women they had operated on. It is worthwhile remembering that risk tolerance tends to go down much faster with negative experience than up with positive experience. Those in the higher percentage acceptability group (and certainly in my experience) have found that both of the often suggested threats of 1) possibly accelerating hair loss when transplanting into still hair-bearing areas, or 2) achieving minimal improvement in such sites, are avoidable. A randomly selected group of 50 female patients I treated from 2003 to 2009 who were asked in a mailed questionnaire: Knowing what you know now, would you do it again? and Would you recommend it to a friend? resulted in only one of them answering "no" to the first question and another one "no" to both. The latter patient was seen for reassessment and changed her mind when she was shown her "before" photos—she subsequently had another transplant. Interestingly, the other patient who did not come in for re-assessment answered "yes" to the second question.

Having observed many hair restoration surgeons operate over the years, I believe the most common cause for poor results in hair-bearing areas (whether in women or men) is the operator incising recipient area sites too quickly and therefore not optimally following the angle and direction of the existing hair. A video of the author making recipient site incisions at typical speed can be found at: http://www.youtube.com/watch?v=xmeYfHh4z_E.

The second most common cause of poor results—especially in women—is an FU/cm^2 density that is too high. It should be remembered that lower graft densities than in men are advantageous for women who generally have the aforementioned smaller donor areas than those usually found in men, and that high graft densities are not necessary to produce very satisfying results in women. This is because women have more hairstyling options than men, long hair optimizes hair coverage for any given number of hairs, and women very rarely lose all of the hair in an affected area. Therefore, the potential cosmetic benefit from any given number of transplanted hairs or FU/cm^2 in an area—typically 20-25 FU/cm^2—is greater (both short-term and long-term) than in men.

Two of the respondents found that only 20% of the women they do magnified trichoscopic exams on during consultations have acceptably low levels of donor area "hair miniaturization." In my opinion, the potential donor areas of women tend to be incorrectly assessed in many cases. Trichoscopy should not be carried out in 4 to 6 "standard" fringe areas as is commonly done in men. Rather, the donor areas are virtually always properly limited to occipital and parietal areas (virtually *never* temporal areas) and they are often more inferior than the usual locations in men. Twenty women with worse than average donor areas but who the author deemed acceptable for hair transplanting, had satisfactory donor areas at approximately the level of and/or inferior to the occipital protuberance. Those areas are shown in violet and blue in Figure 2, as compared to the typical donor area in men, which is shown in the yellow and violet areas. This female donor area would virtually never be assessed during consultations with magnification for miniaturization if the same areas used for male assessments were sampled with trichoscopy. Thus, the patients would be incorrectly rejected. As an example, a patient came to our office one month after having been rejected by a physician in the 20% female candidacy group. "Confused" and "hopeless" were her stated emotions after being informed of her poor candidacy based ostensibly on her poor donor/recipient area ratio. A folliscope exam of 9 regions both within and at the border of her potential donor area revealed an average prospective donor area density of 118 FU/cm^2 and a terminal to ostensible vellus hair ratio of 96:4 (Figure 3). With her well-defined recipient area, this is an example of how an overly conservative approach can be as damaging to the quality of patient care as an overly aggressive one.

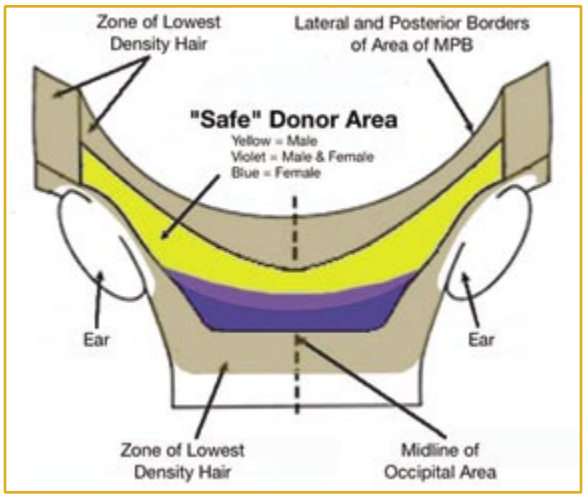

Figure 2. The violet and blue areas represent the acceptable donor area found in 20 women with *worse* than average female donor areas. The typical donor area in men is represented by the yellow and violet areas.

Figure 3. A representative folliscope photo taken in a woman who had been rejected on the basis of an inadequate donor area one month earlier, by one of the 20% group physicians. The average FU density was 118 FU/cm^2 and she had a terminal to ostensible vellus hair ratio of 96:4.

A direct visual search for good potential donor areas should be done before any trichcoscopic examination, and if the latter is unfavorable, it should be repeated, for example, 12 weeks later, to see if some "miniaturized" hairs were actually early anagen hairs that could not initially be morphologically distinguished from truly miniaturized hairs. At the 2010 ISHRS Annual Scientific Meeting in Boston, before I presented a lecture on hair transplanting in females, I asked three widely respected hair experts, Drs. David Whiting, Marty Sawaya, and Jerry Shapiro, if they thought that a single trichoscopic examination could really tell an observer whether somebody had a disproportionate percentage of miniaturized hairs in the area they are examining, or whether they couldn't. Dr. Whiting in essence said he thought the whole exercise was so "useless" that he never (he emphasized the word) used that method to study miniaturization. Instead, he uses biopsies with transverse sectioning. Dr. Sawaya agreed that unless you did a second examination, you could not deduce anything from a single one, and Dr. Shapiro said the same thing (I spoke to him by phone because he wasn't at the meeting). I asked these acknowledged world experts in the study of hair diseases specifically because I wanted to prepare for what I expected to be a vigorous assault on my view. Nobody in the audience attempted to contradict their replies. Let me be clear, however: If a physician is doing more than one examination, I do believe it could be helpful. It's just a single examination that is not nearly as definitive as too many would like to believe.

Conclusion

A substantial majority view of expert hair restoration surgeons (20 of 28) is that at least 40% of patients they see with FPHL have acceptable donor area reserves for at least one session of hair restoration surgery. (Six of 28 thought only 20-25% are acceptable while 8 of 28 thought 70% or more are candidates.) Not all of them should or will proceed because of what the patient (not the physician) views as the cosmetic limitations of a single session, or because of the *short-term* potential sequelae of the surgery, most commonly in the author's experience the approximately 50% incidence of some degree of temporary recipient area hair loss. Donor areas in women are not only more limited than in men but they tend to be lower in the occipital and parietal areas than in men. A single folliscope exam in clinically acceptable potential donor areas is *not* definitive; a negative one should be repeated approximately after three months or later.

Reference

1. Unger, W.P., and R.H. Unger. Hair transplanting: an important but often forgotten treatment for female pattern hair loss. *J Am Acad Dermatol.* 2003(Nov); 49(5):853-860.

Editor's note: Dr. Unger has brought up a very important topic that illustrates that even the most experienced hair transplant surgeons can disagree. What is apparent, though, no matter which group you fall into, is that as the doctor you must do your best to act in the patient's interest. In spite of this, however, we sometimes will "get it wrong." I probably fall into the 50% group with women's surgical recommendations because my patients come from a combination of referrals (e.g., patients, other physicians) and other sources (e.g., Internet). Of the referral sources, those women recommended by dermatologists and plastic surgeons will fall into the 80% group, and of the others it entirely depends on the source. Therefore, when reviewing the figures in Dr. Unger's article, it is important to be cautious and not just take them at face value.

The principle of small operations for women confined to an area just behind the hairline is one that we use in almost all of our female patients with FPHL. It is often quite remarkable the difference in hair styling achieved by a small operation (Figures 1 and 2).

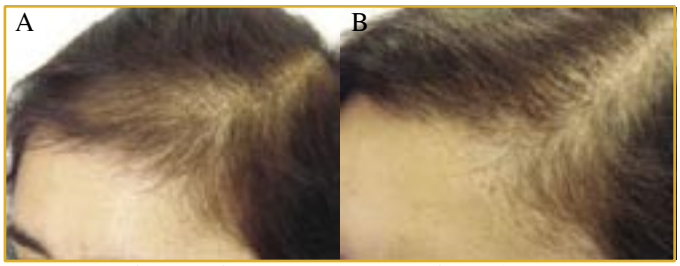

Figure 1. Patient 1: *A:* Pre-op; *B:* 1 operation of 850 FUs.

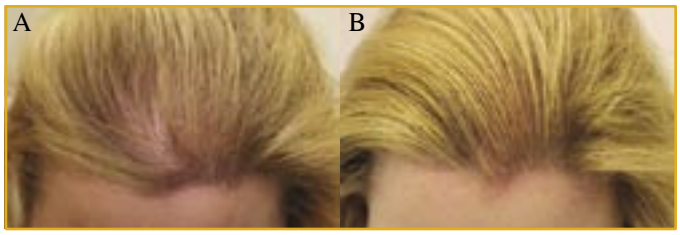

Figure 2. Patient 2: *A:* Pre-op; *B:* 2 operations of 1,300 FUs each.

I agree with Dr. Unger's concept of going lower with the donor area. Because you are confined to a smaller available zone, in order to get sufficient length of donor, you inevitably have to take the donor from a lower site. Dr. Bob Leonard is quite right that women often want the option of tying their hair up, which means we have to avoid going too low. —NF◆

A note from Robert T. Leonard, Jr., DO *Cranston, Rhode Island, USA*
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I would like to comment on Dr. Walter Unger's excellent article discussing the candidacy of women for hair transplantation. As was mentioned, I am a surgeon in the group who believes that more, rather than fewer, women are candidates for this often life-altering procedure.

We must never minimize the fact that we are physicians first and that these female patients are usually suffering—badly—because of the loss of their hair. Evaluation for hair restoration in these patients needs to be carefully, honestly, realistically, and compassionately undertaken.

One of the most important things we must consider is how *little* hair will be enough to make them feel better about their condition:

- To make them be able to more easily prepare for their day.
- To allow them to not have the *"think about their hair all the time,"* which is a common comment made to me by these girls and women.

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Candidacy of females

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- To offer what physicians are supposed to do for their patients—provide relief of suffering, if at all possible for their patients.

Therefore, it is critically important for the doctor during the consultation process to provide *honest* and *realistic* expectations to these women so that they can then make the appropriate decision as to whether or not to undergo the transplant. Tell them what the limitations are with regard to donor availability. Explain to them how large (or small) a surgical session can be to achieve a desired result.

Bigger (or more) is often not better for these patients:

- Often a small session in the area immediately posterior to the hairline will offer them enough hair to style in order to decrease the "see-through" concern about which many complain.
- Too large of a session will cover more area, but often at the expense of density.
- Sadly, (and I sincerely mean this), it is not uncommon for me to see patients who were recommended to have a large number of grafts to cover a large area of thinning. The motivation, I am sure, is monetary and not in the best interest in the patient's well-being.
- A huge number of tiny grafts can do more harm than good. Think about it logically: very often a woman's hair loss is more of a thinning problem versus a balding one. If a surgeon makes a very large number of very small incisions very close to one another within an area that has follicles providing hair coverage to the patient, regardless of how carefully and slowly one creates these incisions, this *will* damage/destroy existing follicles. This approach greatly increases shock hair loss, does damage to follicles that could have continued to produce hair for the remainder of the patient's life, and provides final results that still are quite thin.

Another point I want to offer, especially since the membership of the ISHRS has grown significantly since the days of larger grafts, is that bigger, in some aspects, may, indeed, be better for our female patients.

One of the most wonderful aspects of medical practice is that it takes practice. And, practice does, indeed, make perfect. The longer you are in this magnificent profession, the more you will realize that everything you learned in the past need not and should not be put on the shelf as being no longer useful.

In my experience over these last 25 years in the field of hair restoration surgery, I have seen techniques that have come and gone and then have returned. I also have seen individuals who embrace a particular surgical method and use it all the time in every patient. Some actually, either quietly in the confines of their consultation room or loudly on the Internet, lambaste colleagues who do not agree with their point of view!

I strongly believe that surgeons in this field should utilize any technique that they have in their experience to provide their patients with the best possible results.

So, in my humble opinion, transplanting larger, rather than smaller, grafts in our female patients offers them a fuller, thicker result. Larger grafts, away from the hairline, give these patients more hair with which to style without damaging as many existing follicles and existing growing hair.

The bottom line in evaluating these patients is to understand and to manage their expectations. I, like Dr. Unger, have seen many women who have been rejected as surgical candidates who then go on to have a procedure with me and become extremely happy and satisfied patients. Unfortunately, I also observe the opposite: Women who come in after having huge numbers of minuscule grafts that have destroyed existing hair and have provided very little resultant density—pretty much kicking her while she was down.

In conclusion:

- Be realistic in your evaluations of these vulnerable patients.
- Remember that even a little hair—strategically transplanted—will be therapeutic and satisfying to them.
- Don't be cemented into using only one technique for all of your patients.
- Respect the body's ability to heal.
- First look out for your patients' best interests and not for your deposit slips.
- Thank you, Dr. Unger, for your expertise and mentorship through the years.
- Continue to be excited and feel blessed to be a part of this exceptional Society and profession!◆

A note from Ed Epstein, MD *Virginia Beach, Virginia, USA*
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Recently I participated in a survey by Dr. Walter Unger in which I responded that only 20-25% of women with FPHL in my practice were HT candidates. Ten percent of hair transplants in my practice are women, as I tend to be more conservative in the selection process. While the donor areas of most women can support a single 800-1,200 graft session, many have donor supplies limited to the occipital area, average or sub-optimal density, and/or fine texture, which either excludes them from higher graft number sessions, or may provide results that, while an improvement, may fall short of patient expectations, even when those potential less dense results are thoroughly discussed. Dr. Unger's observation of higher density below the occipital protuberance is interesting, but I have concerns about scar widening in this area as well as potential scar visibility when the hair is pulled up and worn on top of the head. The phenomenon of post-procedure shedding, despite slow and deliberate site placement and reduced use of epinephrine, is disconcerting to both patient and doctor, and, in my hands, contributes to a more conservative approach in patient selection.◆