

Letters to the Editors

Mark Andrews, MD Beverly Hills, California, USA
AZ244@sbcglobal.net

Re: Unilateral poor growth

After reading the editorial comments of Dr. Reed (*Hair Transplant Forum Int'l.* 2011; 21(3):67), I felt compelled to add an observation of my own. In 16 years of hair restoration surgery I've noticed a repetitive phenomenon that I've not seen reported or acknowledged in print: unilateral poor growth, seen almost exclusively on the left hairline but occurring on a continuum occasionally affecting the entire left side of the treated area (but never seen with punch grafts) (see Figure 1).

Early on, I had assumed that a less-experienced staff member was the source of the problem and would try to correct it in a subsequent procedure. Interestingly, never could any individual staffer be consistently incriminated. Furthermore, as increasing magnification became the norm, I noticed that, in reinforcing the hairline in follow-up sessions, there would be more "space" (i.e., less hair) on the left even in those results that passed as "good" or better to the naked eye. Thus sensitized to the problem, I find it in most patients from many different practices and surgeons from all over the country, even in patient photos used for marketing purposes. Figure 2 depicts what most of us would consider a good hairline; Figure 3 is identical but with lines drawn through the lowermost grafts (as if prepping for a repeat procedure)



Figure 1. Examples of lower density on left side of recipient area.



Figure 2. Final result of a transplant.



Figure 3. Same result as in Figure 2 but with line revealing poorer growth.

the discrepancy becomes obvious and in my opinion represents failure of the grafts of the leading edge of the hairline on the left.

The explanation for the above would seem to be "handedness." Mainly right-handed placers must "grasp and pull" grafts into sites whilst lefties can "push and nudge" with presumably less squeezing forces. This also allows for the existence of the rarely seen right-sided failure (presumably from a lefty placing on that side). So, traumatic placement would be the logical explanation.

However, for those of us with a conspiracy theorist mentality, I offer a biostatistically unvalidated observation: The right side, especially at the hairline, seems to bleed more. Years ago, I was dismissive and scoffed at such a notion when more experienced staffers told me this. (Sorry, I guess that's two "observations").

Editor's note: Other considerations could, I suppose, be that the "handedness" of the surgeon results in a different density or quality of slit on the left side vs. the right, and I'm sure that, with the experience reflected in his insights above, Dr. Andrews has considered and eliminated these variables. Searching for these subtle differences is what must be done by each of us to get the highest frequency of optimal results. I request each of us to follow Dr. Andrews's example in sharing such reflections. —WR ♦

Jeffrey S. Epstein, MD, FACS Miami, Florida, USA
jsemd@fhrps.com

Re: The efficacy of new technology

Appearing in the June 26 Sunday New York Times, an article entitled "In Medicine, New Isn't Always Improved" discussed how the promise of innovation, in this case a metal-on-metal hip implant, is not always a positive development. Both manufacturers and physicians alike have a financial interest in incorporating new technology as a way of charging more and gaining an edge on competitors. I believe we have a similar situation within the hair transplant field, and the past two issues of the *Forum* have featured articles on these two new developments that have received a lot of attention: the NeoGraft® device, and ACell tissue technology.

The NeoGraft device is being heavily marketed directly to the lay public primarily through the Internet as a superior alternative to traditional hair transplants and to cosmetic surgeons as a convenient way to add hair transplants to one's practice.

Meanwhile, ACell was introduced with much fanfare at the ISHRS meeting last fall (October 2010), generating a tremendous amount of excitement amongst hair transplant surgeons and to the hair loss community who rapidly jumped at the reports of "autocloning," reduced scarring of donor sites, and improved hair regrowth percentage. I, too, am guilty of falling into this trap of

competitive advantage. That, coupled with the goal of achieving the best results for my patients, led me to immediately purchase thousands of dollars worth of ACell and offer it as part of my hair transplant procedure. During those first two months following the October reporting of ACell, I had no fewer than 3 patients cancel procedures with me in favor of the surgeons who were offering plucked beard "autocloning," a technique of which I (and many of my colleagues) have been skeptical. My skepticism, among other reasons, is that I had seen just one legitimate case presented at an ISHRS annual meeting five or more years ago (in which no ACell was utilized). I rapidly set out to see for myself the potential advantages of ACell in several areas, including in donor site healing and graft regrowth percentage.

For donor site healing, an ACell sheet was placed in one-half of the donor site, comparing the scar to the other half in which no ACell was placed. Without exception, in the 8 cases on which I had weekly to monthly follow-up (out of a total of 24 cases in which I used the ACell), the ACell half of the donor site had prolonged erythema, and at 6 months the scar was redder and wider.

For the regrowth percentage in the recipient area, I soaked grafts in ACell prior to implantation onto one side of the scalp with plans to compare regrowth to the other half of the scalp in

which the grafts were not soaked in ACell. In the 24 cases in which I used the ACell, at 6-7 months post-op, I have seen a total of 3 patients (in fact one today as I write this) and there was no grossly noticeable difference in regrowth rates. While far from having any hard-line scientific merit, these observations, especially with the donor site scarring, were sufficient for me to stop offering it to my patients.

I find it troubling that there has been no new evidence presented on the efficacy of ACell since its description 8 months ago. The absence of further information only serves to perpetuate the perception of ACell perhaps erroneously as a wonderful innovation. This likely continues to create false expectations both in the hair loss public as well as with less experienced (and less skeptical) colleagues. Will there be the same desire, assuming the claims of its efficacy prove with time to be overstated, to correct these misperceptions and inaccuracies?

Similarly, the marketing of the NeoGraft by surgeons' tes-

timonials and the manufacturer (I refer you to their website) is creating false expectations, much in parallel with the perception of the FUE procedure as a wonder procedure: great results without any donor site scarring. In my rather extensive 4-year experience with FUE, performing over 450 of the procedures (approximately 20% of the hair transplant procedures I perform), I have found its reliability in terms of regrowth percentage to be lower than that with the strip procedure. I see no advantages to the NeoGraft that would suggest that its use would somehow create higher graft regrowth percentage.

As leaders in the hair transplant field, and as physicians, we are obligated to transparency. Lectures at scientific meetings, interviews on websites, and published articles in non-peer reviewed but valuable publications like the *Forum* provide clinicians with tremendous power to influence public (and fellow colleagues') perceptions. We must embrace this power judiciously, placing the interests of our patients before all other considerations. ♦



Luiz A.S. Pimentel, MD Rio de Janeiro, Brazil
luizpimentel@gmail.com

Re: Reply to David Perez-Meza on tissue adhesives

I would like to thank Dr. David Perez-Meza for his comments on my paper in which I reported the use of tissue adhesives (*Hair Transplant Forum Int'l.*, 2011; 21(2):50) and would like to clarify the following to Dr. Perez-Meza and other readers.

The published case (Figures 1 and 2) intended to show colleagues a decision I made in a case where there was a high number of graft extrusions (popping effect), which was causing severe delays to the surgery. The article is not intended to recommend the routine use of cyanoacrylate in hair transplantation. We all know that there is possibility of an inflammatory reaction, but based upon my previous experience with the use of cyanoacrylate as a skin tissue adhesive in plastic surgery during which I had never observed any adverse cutaneous reactions, I got the courage to use it. Until that moment I had never thought about this type of use.

The glue was not applied individually to each graft after insertion. What we did was to make the insertion of 600 FUs using more space to avoid the pop up, and then we applied one coat of the glue all over the bald area. Cyanoacrylate formed a protective film on the inserted grafts. After this coat was dry, we made new incisions through the formed film. Seven hundred FUGs were placed into these new sites made between the previously placed 600 grafts without the popping that had occurred with our earlier attempts prior to applying the glue. It was observed that when making incisions with blades (straight cut), the dry film of

cyanoacrylate partially closed upon the FUGs preventing their extrusion, thereby allowing placement with smaller spacing. It was important to make incisions with blades. Incisions using needles (semicircular cuts) did not allow for the same effect of prevention of popping.

I would like to further clarify that due to the close-up view in the photos, the patient's head looked bigger, but in reality there was no inflammatory reaction or severe oedema greater than that usually experienced. The shape of the skull and its tilted forward position also contributed to this appearance of abnormal oedema. This patient had thin, very mobile skin. It was observed that the injection of tumescent anesthetic solution was a cause of the popping, and also of greater oedema. Continuing this research, based upon the publication of D'Assumpção on using 2-ethyl cyanoacrylate (Low cost cyanoacrylate adhesive in plastic surgery, *Rev Soc Bras Cir Plast.* 2008; 23(1):22-25), we used the same glue cited by this author (Super-Bonder) in another patient, and it was possible to observe the formation of a thicker film with only one coat, and the glue worked better than 2-octyl cyanoacrylate (Dermabond) in preventing the popping

I believe that we should not routinely use cyanoacrylates, but in cases of intense popping we can adopt this procedure with relative safety. Now a test of skin sensitivity to cyanoacrylate has become part of my preoperative conduct.

I do not use adhesives to suture the donor area. ♦



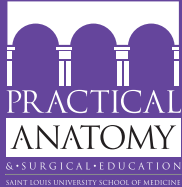
Figure 1. Pre-operative photo.



Figure 2. Total hair growing from first hair transplant at 18 months post-op.



Sponsored by



New, Expanded, World-Class Faculty
New, Expanded and Combined Level 1 and 2 Lectures
New, Expanded and Tailored Hands-On Lab Experience
3D Live Cadaver Demonstrations

3rd Annual Hair Restoration Workshop

An offering through Practical Anatomy & Surgical Education
Saint Louis University School of Medicine

- ▶ *Hairline Design*
- ▶ *Donor Harvest/Closure*
- ▶ *Recipient Site Creation*
- ▶ *Graft Dissection*
- ▶ *Graft Placement*
- ▶ *Crown Design*
- ▶ *Female Hairline Design*
- ▶ *Temporal Point Design*
- ▶ *FUE*
- ▶ *Graft Calculation*
- ▶ *Eyebrow Transplant*
- ▶ *Marketing*
- ▶ *Consulting*
- ▶ *Medical Treatment*
- ▶ *Critical Thinking Day*
- ▶ *Quality Control*



Course Director
Samuel Lam, MD

Physician Faculty
Paul Cotterill, MD
Vance Elliott, MD
Robert Haber, MD
James Harris, MD
Paul McAndrews, MD
Robert Niedbalski, MD
Lawrence Samuels, MD
Ronald Shapiro, MD
James Vogel, MD

Assistant Director
Emina Karamanovski, MD

Assistant Faculty
Tina Lardner
Kathryn Morgan
Kasia Muzyka
Charlene Smith
Janna Shafer
Carol Wade

October 14 - 16, 2011

Follow us now on   **St. Louis, MO, USA**

REGISTER On-Line at <http://pa.slu.edu>

Seminar Information
Practical Anatomy & Surgical Education
3839 Lindell Blvd., St. Louis, MO 63108

Phone: (314) 977-7400
E-mail: pa@slu.edu
Website: <http://pa.slu.edu>

Collaboration with



Surgical Assistants Corner

Patrick Tafoya Orlando, Florida, USA patrickatafoya@yahoo.com



Design elements in zone planning for hair transplantation: part I

Patrick Tafoya Bosley Medical Group, Orlando, Florida, USA

Utilizing design elements in zone planning is essential to the success of hair restoration. First, the surgeon must develop an appropriate aesthetic plan and, second, the surgeon must clearly communicate this plan to the surgical technicians assigned to dissect and implant grafts.

The definition of zone planning is the proposed manipulation of ideal grafts into designated areas of balding to optimize preconceived results. The preconceived result is first initiated through the patient's "self image," which is conveyed during the consultation. It is the surgeon's job, however, to help the patient gain a realistic expectation of the overall result. For this, a surgeon must rely on his or her previous experience and be sure to carefully assess the physical characteristics of the patient's hair (color, density, texture, etc.) as well as the extent of male pattern baldness (MPB) in order to develop a realistic transplant plan offering attainable results. After the initial consultation, the physician will formalize the surgical plan based on these elements.

Baldness patterns vary in form, shape, and dimension. The resulting pattern can be separated into "zones." Understanding the qualities of the separate zones is essential to the surgical plan. Since all patients have a limited donor supply and hair loss is progressive, it is important to realize that full coverage is improbable. Instead of providing "full" coverage, we can only help provide the "illusion" of coverage. Design elements are then utilized to emphasize this illusion.

Design Elements

Design Elements are defined as the building blocks used to create a work of art. The elements of design can be thought of as the things that make up a painting, drawing, or any type of creative design, and can include the following:

- Line
- Shape
- Direction
- Size
- Texture
- Color
- Value

The Principles of Design

The principles of design can be thought of as what we do to the elements of design. How we apply the principles of design determines how successful we are in creating a work of art. These include the following:

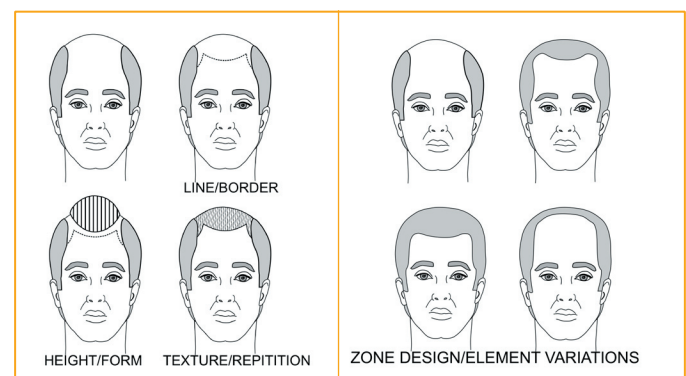
- Balance
- Gradation
- Repetition

- Contrast
- Harmony
- Dominance
- Unity

The Hair Transplant Surgical Plan

Before the surgical plan is developed, the physician must approximate the number of hairs available per surgery (density, laxity, and length of potential donor strip), the extent of baldness (dimensions, amount of existing hair, etc), and the physical characteristics (texture, color, and curl). Based on this assessment, the surgical plan is designed to maximize the zone coverage and maintain its individual characteristics. The following are basic design elements used to create the "illusion" of coverage:

- *Line*: Establishes boundaries and creates proportion (hairline).
- *Form*: Creates height and visual strength (stronger multiple hair grafts in frontal forelock area).
- *Texture*: Establishes direction and shingling effect (crosshatching).
- *Repetition*: Random/even distribution of grafts (perceived density and naturalness).



Left: Design elements in hair restoration. Right: Variations in zone planning.

Conclusion

The surgical plan is the aesthetic agreement between the hair transplant surgeon and the patient's realistic expectations of the proposed result. The transplant team's success in achieving realistic expectations relies on the physician's clear communication with the surgical assistants in respect to the design elements and zone planning. Thus, the surgical assistants will have a plan that allows for them to dissect the most appropriate grafts and implant them into the appropriate hair loss zones so that the patient has the best results possible for him or her. ♦

Classified Ads

To Place a Classified Ad

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

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

REGISTRATION OPENING SOON!

ISHRS “On Demand” Webinars Enduring Material, Online Format

The ISHRS is pleased to announce its new On-Demand Webinars. The recorded webinars are 60 to 90 minutes in length. You can listen to the webinars 24/7/365. In other words, you can listen to them whenever it is convenient for you. Below is list of the latest recorded webinars. Additional programming is under development.

Going Viral: Unlocking the Secrets of Social Media for Hair Transplant Patient Education and Beyond

60 Minutes; 1.0 CME Credit

Faculty: Alan Bauman, MD

Description: The On-Demand Webinar Program titled *Going Viral: Unlocking the Secrets of Social Media for Hair Transplant Patient Education and Beyond* is an enduring material created by the International Society of Hair Restoration Surgery (ISHRS). This On-Demand Webinar Program is intended for an audience of all levels. This enduring material was developed first as a symposium offered at an ISHRS Annual Scientific Meeting in 2010. Dr. Alan Bauman, a well-known and distinguished expert in the field of hair restoration and self-proclaimed “techno-geek,” developed the materials and content based on the pre-determined learning objectives and with the guidance of the CME Committee.

Intro to Biostatistics & Evidence Based Medicine

90 Minutes; 1.5 CME Credit

Faculty: Jamie Reiter, PhD and Jerry E. Cooley, MD

Description: This webinar will provide basic information regarding proper research design and statistics for investigators in hair restoration surgery, through didactic lecture and dialogue between presenters. It is intended to address the needs of the more common research questions in hair restoration surgery. Specific research questions may require more advanced instruction.



CELEBRATING

20 YEARS

EDUCATION
RESEARCH
COLLEGIALITY

20TH ANNUAL SCIENTIFIC MEETING

BAHAMAS

ATLANTIS-PARADISE ISLAND, THE BAHAMAS • OCTOBER 17-21, 2012

SAVE THE DATE
OCTOBER 17-21, 2012

CALL FOR ABSTRACTS

Opens in December 2011. Visit the ISHRS website for more details: www.ISHRS.org/AnnualMeeting.html



International Society of Hair Restoration Surgery • 303 West State Street, Geneva, IL 60134 USA • TEL 1.630.262.5399 or 1-800-444-2737 • FAX 1.630.262.1520
info@ishrs.org; www.ISHRS.org



Advancing the art and
science of hair restoration

Upcoming Events

Date(s)	Event/Venue	Sponsoring Organization(s)	Contact Information
DIPLOMAS Academic Year 2011-2012	Diploma of Scalp Pathology & Surgery U.F.R. de Stomatologie et de Chirurgie Maxillo-faciale; <i>Paris, France</i>	<i>Coordinator: Pr. P. Goudot</i> <i>Directors: P. Bouhanna, MD, and M. Divaris, MD</i>	Tel: 33 +(0)1+42 16 13 09 Fax: 33 + (0) 1 45 86 20 44 sylvie.gaillard@upmc.fr
January 2012	International European Diploma for Hair Restoration Surgery	<i>Coordinator: Y. Crassas, MD, University Claude Bernard of Lyon, Paris, Dijon (France), Torino (Italy), Barcelona (Spain), Department of Plastic Surgery</i> www.univ-lyon1.fr	For instructions to make an inscription or for questions: Yves Crassas, MD yves.crassas@wanadoo.fr
October 14-16, 2011	3rd Annual Hair Restoration Surgery Cadaver Workshop <i>St. Louis, Missouri, USA</i>	Practical Anatomy & Surgical Education, Center for Anatomical Science and Education, Saint Louis University School of Medicine in collaboration with the International Society of Hair Restoration Surgery http://pa.slu.edu	http://pa.slu.edu
November 12-13, 2011	3rd Annual Meeting of the Association of Hair Restoration Surgeons of India (HAIRCON-2011) <i>Mumbai, India</i>	Association of Hair Restoration Surgeons of India www.ahrsindia.org	Tel: + 91-9821 308411 drjajeshrajput@gmail.com
October 17-21, 2012	20th Annual Scientific Meeting of the International Society of Hair Restoration Surgery <i>Paradise Island, Bahamas</i>	International Society of Hair Restoration Surgery www.ISHRS.org	Tel: 630-262-5399 Fax: 630-262-1520

HAIR TRANSPLANT FORUM INTERNATIONAL

International Society of Hair Restoration Surgery

303 West State Street
Geneva, IL 60134 USA

Forwarding and Return Postage Guaranteed

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

Dates and locations for future ISHRS
Annual Scientific Meetings (ASMs)

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