HAIR TRANSPLANT forum INTERNATIONAL

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*Inside this issue*




# The surgical management of frontal fibrosing alopecia

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The surgical management of any progressive/unstable cicatricial alopecia can be challenging. The risk of reactivation of "dormant" or "burnt out" disease in the lymphocytic and neutrophilic versions must be considered. Different physicians have different rules in assessing suitability, but it appears most would recommend 1-2 years of stability of the disease before considering surgical treatment.

In my personal experience, some cases of lichen planopilaris (LPP) have reactivated, but the patients were no longer on medical therapy at the time of surgery. On the other hand, cases of pseudopelade have never reactivated in my experience, and I also have a 5-year post-surgery patient, who previously had folliculitis decalvans (FD), who has fully maintained his successful graft transplants. This leads me to conclude that many patients with LPP, FD, and pseudopelade can be suitable for grafting even if no longer on medical treatment. They must, however, be continuously monitored for any evidence of disease reactivation.

My recent experience with frontal fibrosing alopecia (FFA) leads me to a different conclusion, and I now regard FFA as a special category when considering surgical management. My 66-year-old patient, JD, first presented to me in 2008 with a 4-year history of FFA (Figures 1 and 2). The disease had been "stable" for over 12 months and though she had previously used hydroxychloroquine, she was currently only using occasional topical tacrolimus. After checking with her dermatologist and waiting to see if any progression was occurring, I scheduled her surgery for her 8 months later, mid-2009.

The first of two planned surgeries involved 2,048 grafts (Figures 3-7), and 5 months later a second surgery of 2,130 grafts was performed. The results were excellent (Figures 8 and 9). I did not see JD again until 3 years later in late 2012. She reported 2-3 months of loss of transplanted hairs at the frontal hairline (Figures 10 and 11). There were clinical signs of active peri-follicular inflammation and she appeared to have oral mucosal LPP, too. I recommenced her on hydroxychloroquine and referred her back to her dermatologist. The hydroxychloroquine quickly settled her inflammation and no further hair loss eventuated over the following 4 months (Figures 12 and 13).

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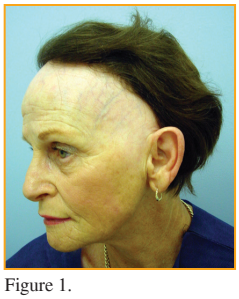
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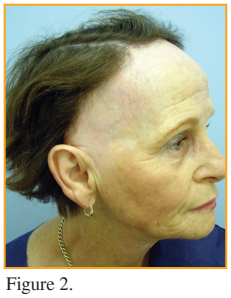
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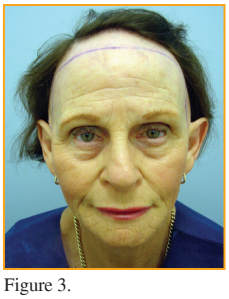
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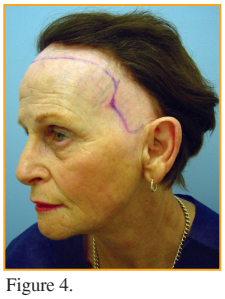
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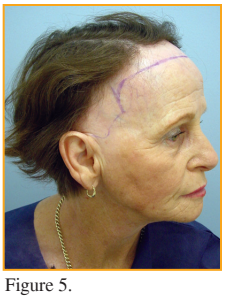
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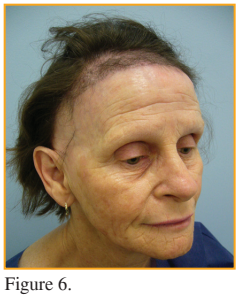
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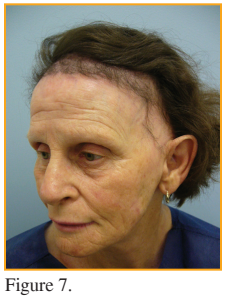
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Figure 8.


Figure 9.

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# President's Message

Carlos J. Puig, DO *Houston, Texas, USA*
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I just returned from Athens, Greece, where I attended the DHI Masters Forum. It was indeed exciting to gather with physicians from all over the world to discuss HRS therapeutic options and compare outcomes. The DHI hair restoration surgeons presented not only their positive results, but also honestly presented a few less-than-optimal cases to discuss and develop therapeutic options to avoid repeating the outcomes. Konstantinos Giotis has assembled an enthusiastic group of patient-focused physicians and created a business atmosphere where the entire staff is interested in continuously improving their patients' results.

I suppose I have a bias toward working in that kind of practice environment, as I tried to do the same thing both in the Puig Medical Group back in the 1980s and 1990s, and again with Matt Leavitt at MHR between 2000 and 2008. An advantage to practicing hair restoration surgery in a large group is that processes can be standardized, and a statistically significant number of patient outcomes can be tracked to provide solid data from which to draw improvement strategies.

Over the past 20 years we have seen dramatic improvements in the art and science of hair restoration surgery. The average patient outcome is so natural looking that few are ever noticed in public venues. In fact, many of our junior membership have never seen nor been trained in many of the generally accepted techniques we used in the 1970s and 1980s.

I attribute the rapid technological improvements we have seen to the ISHRS's encouragement of open and frank communication amongst its members at scientific meetings, in public forums, and in private communications. I encourage you to think about how much more we can accomplish if we work together to develop investigational protocols searching for outcome improvements.

We have long recognized that our young specialty falls short and needs more focus on evidence based medical studies concerning our therapeutic interventions. The ISHRS has been taking steps to encourage the membership to participate in developing sound research protocols looking at what really enhances outcomes. The ISHRS has been conservatively managed since its inception, is financially sound, and the Board of Governors feels that it is time to reinvest in our profession. This year the Board of Governors increased the annual budget for research and study grants from $12,000 to $65,000USD, in an effort to encourage the membership to become more involved in looking for evidence based therapeutic interventions.

The FUE Research Committee, chaired by Dr. Parsa Mohebi, is drafting two or three protocols intended to compare and contrast FUE graft injury and survival with that of strip harvesting. Drs. Ken Williams and Bob Reese are studying the effect of PRP injections in Female Patterned Hair Loss in a double-blind, placebo-controlled study. There are other studies in the pipeline as well.

In the ISHRS, I find myself surrounded by physicians with brilliant minds. We are often critical of each other's positions and work, but those criticisms are healthy, and intended to drive our combined experience into doing better surgery. I encourage the entire membership to come together in small study teams, as though they were in a large group practice, to design and complete protocols that will help us improve the quality of the services we provide our patients through sound evidence based medicine. Remember, "One cannot discover new lands without getting out of sight of old land." And getting out of sight of land is a lot less frightening when traveling with a trusted friend. We can achieve so much more by working together.◆

# Co-editors' Messages

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

For as long as I can remember, there has been the debate about which doctors can perform aesthetic procedures and many specialist groups have claimed the remit that cosmetic surgery falls within their specialty alone. Regulators in different countries have tried at times in the past to deal with this issue and each time a new government wants to show that it is tackling matters of public concern; medical care often comes to the forefront. Some countries, such as Turkey, for example, now restrict which doctors can perform surgical hair restoration procedures. One of the articles published in this edition is an update from Dr. Jean Devroye on the regulations that are being proposed in the European Union in relation to performing cosmetic surgery. The ISHRS has been involved in liaising with him and the European committee that has been set up to tackle this very contentious area. I encourage you to read the update, which makes for interesting reading not least the fact that hair transplantation in Belgium is classed as a non-surgical procedure. Greg Williams also updates us on some of the proposals coming from the UK in regards to regulations.

In Bill's editorial there is further discussion on regulatory issues especially in relation to the surgical assistants' participation in surgery. He also discusses a critically valid point about Standards of Practice. Here in the UK, we now have annual Appraisals along with revalidation of our licence to practice once every 5 years, which is mainly based on these appraisals that include colleague and patient feedback and CME. In addition, there are moves to tighten regulation in many areas of practice but especially so in the aesthetic surgery and medicine disciplines. Since we know that new regulations are inevitable, and because the number of hair transplant surgeons in the UK is only a small number, we are trying as a group to set processes in place so that we can fight our corner when the time comes. One of the main items on our agenda is getting the members of the British Association of Hair Restoration Surgery (BAHRS) to sign a Code of Conduct that will include agreement to abide by a set of standards for hair transplant surgery that is based on *Professional Standards for Cosmetic Practice* (published by The Royal College of Surgeons of England). In the September/October issue of the *Forum,* some of the specifics of the standards of practice for hair transplant surgery will be discussed under a review of the recent BAHRS annual meeting. One of the key items will be continuing education specific to hair transplantation, including attendance at an ISHRS annual meeting and an ISHRS-sponsored workshop at least once every 5 years. With the increase in the number of and locations of regional workshops, it will be easier for our members to meet this commitment.◆

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

In editing articles for this issue, I was a bit flabbergasted with feedback from the ISHRS regarding one of our articles. The original draft of the excellent article by Tina Lardner and Jim Harris in this issue's "How I Do It" advocated surgical assistants (SAs) removing the grafts made with FUE. The Executive Committee of the ISHRS (EC) was opposed to having this approach appear in the *Forum* lest it appear that the ISHRS was sanctioning this as a standard of practice.

Huh? I put on my reading glasses to be sure of what I was seeing. After all, hasn't that horse long been out of the barn? Haven't SAs been removing grafts from FUE all over the world for years now? Bottom line is that Ms. Lardner's statement seems to have brought into focus for the EC the issue of "what is the ISHRS?". They concluded that it has never intended to nor does it now want to get into defining "standards of practice."

Why should we not be at the center of establishing the standards of practice? Earlier in my three-year tenure as editor, I had written a couple of editorials advocating just such a role for the ISHRS. These editorials came amidst physicians decrying the "consumer websites" that have filled a void on the Internet to assist a patient's search for a quality hair transplant surgeon. One could argue that a website's assessment of "quality" is based essentially on hearsay, and that the judgment rendered might be clouded by the site consequently receiving money from these alleged "quality" surgeons. (A judge in our legal system would have to disqualify himself from ruling on a case with such conflicted self-interests.) Nonetheless, my position was, and is, that physicians should "put up or shut up," that is, we should have a physician-based group determine and enforce quality or stop whining that another group of individuals performs this important function. Perhaps the American Board of Hair Restoration Surgery is moving toward fulfilling this goal.

So why should we, the ISHRS, not define standards of practice? I called our outstanding president, Carlos Puig, and an education of nuance ensued. The ISHRS has long been clear that it exists to serve doctors by being a forum for physician education, collegiality, and dialogue. That it has been true to these values is shown by its efforts to help physicians share ideas via meetings, and I think most of us agree that this, in combination with the evolution of technology, is what has moved the field of hair transplantation forward at the rapid speed seen in the past 20 years. Defining "Right" and "Wrong" (i.e., standards of practice), creates a schism of disagreement and discord that would destroy these factors of our success—educational dialogue, collegiality, and therefore continuing technological evolution. There have been religious wars too numerous to relate that have resulted from the schism created by what is "Right."

Dr. Puig emphasized to me how the ISHRS tries through membership surveys to identify and clearly enunciate the "Standard of Care," but not to define it. The standard of care is fluid, changing as technology advances. One must also remember, he notes, that not all technological advances are beneficial to the patient, and often it takes years of experience to identify the limitations or pitfalls of new technologies.

Additionally, further complicating the incompatibility of standards of practice with collegiality and dialogue is the

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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.
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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 2013 issue
October 5 for November/December 2013 issue

## Reed Message

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diversity of our Society and its worldwide membership. Can one standard of practice apply to such a diversity of cultures and values? If we look only at the USA and Canada, we see a diversity of law such that in some states, but not in others, many of the routine processes involved in hair transplant procedures are restricted to physicians or RNs. Stick-and-place by surgical assistants is case in point. Ultimately, Dr. Puig asserts the ISHRS position is that identification of the component steps of the hair transplantation process that are deemed critical to quality should not be delegated but must be the responsibility of every individual surgeon. The ISHRS cannot take a position that encourages physicians or hair technicians to practice outside of their scope of practice as it is defined by their local jurisdiction.

Ms. Lardner and Dr. Harris's excellent article stimulated a valuable set of reflections by the EC of the ISHRS that define what purpose it strives to serve. Even though a member for 20 years, I'm still learning about my society. A moment of clarification such as this comes to me infrequently, so I wanted to share it with you. The responsibility for ethical behavior that protects our patients is most assuredly the responsibility of each of us, the individual surgeon. The ISHRS hopes to provide a forum for discussions that can help each of us be confident that our thinking is clear when our patient's well-being is considered. This is how it must and should be for the ongoing evolution of our specialty.◆

# Notes from the Editor Emeritus

Robert S. Haber, MD *Cleveland, Ohio* HaberDerm@gmail.com

The first thing I was taught when I began my Fellowship with Dr. Dow Stough many years ago was that constant change was the hallmark of a state-of-the-art practice. When I proudly informed him that as a dermatology resident I had incorporated an advanced technique he had published, he scoffed and told me he had abandoned that technique for something new even before the article was published. And indeed I observed—and then participated in—the evolution of his approach during my year with him, until the constant search for a better way became part of my fabric.

I also learned about change from my father, who at 88 is still working part-time as an electrical engineer, and who successfully transitioned from slide rules and vacuum tubes through iPhones and microprocessors by embracing the new and mastering its language in his lifelong quest to avoid being left behind.

Thus, I never tire from visiting practices and attending meetings where I am always on the lookout for a new ingredient for my hair restoration recipe. Of particular significance this year was the construction of my new office, and I wanted to incorporate every advanced idea I could find. In the past year, I have visited four offices. Russell Knudsen has a gleaming, inviting, and warm but professional office in Sydney. From that visit I incorporated a shower, cove flooring, an instrument cart, and the use of large tiles in my rest rooms. Bob Bernstein has a highly efficient office in New York City, where space is at a premium. From his office, I gleaned ideas regarding designing my consultation room, incorporating the ARTAS robot into my practice, decided to try one of John Cole's cooling units, gained ideas about onsite marketing, learned of a laser guided infrared temperature monitor, and decided that I too would strive to have a clear desk at the end of each day (still working on that). I also visited Marc Avram's Fifth Avenue office in New York, where I learned more about incorporating the ARTAS, patient flow, and using web cams to monitor the office. And from other visits and conversations, I've incorporated ideas from the offices of Drs. Stough, Jerry Cooley, and Ron Shapiro. It certainly is beneficial to have intelligent friends.

But it's hard to compare any office with the new ultra-modern, multi-floor hair restoration palace recently built by Drs. Bessam and Nilofer Farjo in Manchester, England. Their facility is filled with whiz-bang gadgets and high-tech controls for ventilation, audio-visual, window coverings, lighting, and security cameras. They hosted an international workshop in April that showcased elegant reception and consultation areas, spacious and efficient surgical rooms, a conference room featuring an interactive whiteboard, passages secured with magnetic locks, and more. From this visit I'll be adopting better loupes for my staff to improve their ergonomics, a hair wash station, and protocol to keep my patients cleaner, convenient self-supporting finger cups to hold grafts, a small vacuum to clear cut hair, and a more visible hairline marking pencil. I also became very thankful that I do not have to discard all of my surgical instruments at the end of the day.

Attending the World Congress for Hair Research in Edinburgh in May did not advance my surgical agenda, but it did make me aware of gaps in my basic science knowledge, and resulted in ideas about incorporating more basic research into my surgical practice.

Probably the most significant change to my practice will be the incorporation of robotic FUE. I'm one of those practitioners who simply does not enjoy spending hours harvesting grafts. I have witnessed firsthand the gifted techniques of Drs. Jim Harris, Jose Lorenzo, and others, and I admire the endurance that they and the other FUE experts of the world display. But I find the FUE process more technical than artistic, and thus a technique that lends itself to automation. Graft implantation is also more technical than artistic, but most attempts to develop devices to assist in this step have been unsuccessful. I am acutely aware of the controversies surrounding this technology, and personally have no plans to turn the control of my robot over to improperly trained and certified hands. My personal conclusion is that while the ARTAS robot is not yet a match for the small elite group of FUE experts, it can expand the availability of high-quality FUE to other practitioners. For me, how my follicular units arrive in my dish is less important than how they are placed into a sophisticated hairline, and how they grow. With the robot, I can concentrate more on the latter than on the former. I do not yet have results that demonstrate the wisdom, or lack thereof, of my decision, but if worse comes to worse, it will simply be time for another change.

Change that is never welcome is the loss of a friend. Brad Limmer's recent and unexpected death was a sucker punch to the gut. His laugh, his smile, his enthusiasm, his energy, and his surgical skills were things I counted on enjoying for many, many years to come. I'm not placated by observations that he's "in a better place," that "he's with the Lord," or that "he's at peace." Good people like Brad are hard to come by, and his death leaves a gaping hole in the ISHRS fabric that binds friends together from around the world. In Bobby's poignant eulogy, he wisely reminded us to hug our children every chance we get. Goodbye Brad—I do hope you are at peace.◆

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## FFA

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As she was keen to restore her hairline, I agreed to a third surgery that was performed in January 2013. On this occasion 1,526 grafts were implanted. At review by her dermatologist in May (4 months post-surgery), she had no signs of inflammation and her latest grafts were growing in nicely. She is currently using hydroxychloroquine 400mg daily and topical tacrolimus.

Other surgeons have reported loss of grafts in patients with FFA. Dr. Paco Jiminez reported 3 FFA patients with grafted hair loss at the World Hair Congress in Edinburgh in May 2013. Dr. Richard Shiell reports that he has a male patient with FFA who has had repeated surgeries for grafted hair loss over the past 20 years. This raises the question: Does FFA ever really become "stable"?

In view of this case, and other reported cases from colleagues, it is my view that FFA patients should become surgical candidates only if they have no clinical signs of disease, are taking appropriate treatment for the condition, and are prepared to take life-long therapy post-operatively.◆

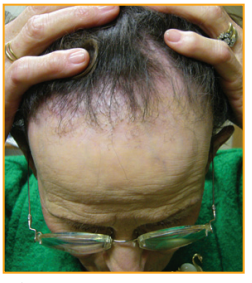


Figure 10.

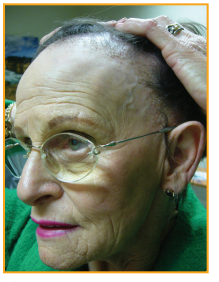


Figure 11.

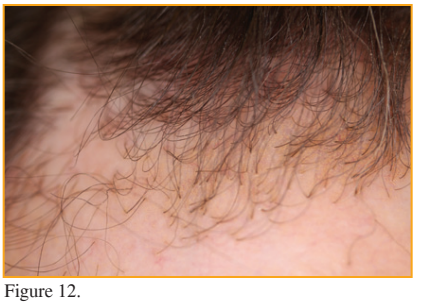


Figure 12.

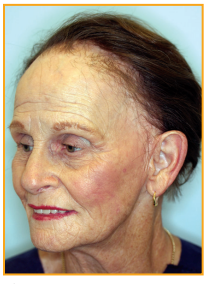
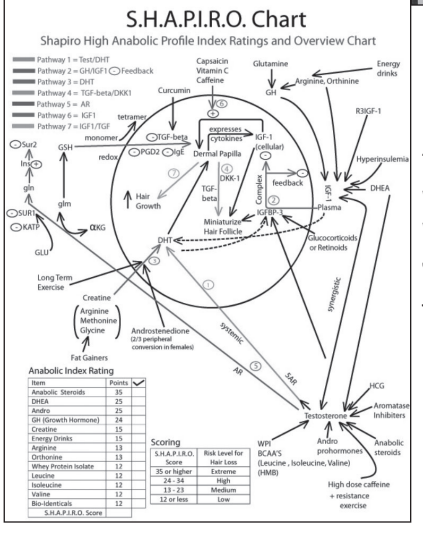


Figure 13.


# Why Wait for Results?

## Help Hair® Shake

Dr. Larry Shapiro lecturing in Rome in 2012.


The Low Anabolic Profile with S.H.A.P.I.R.O. Chart will be published in the JSCHR peer review journal. Dr. Shapiro will be lecturing as a faculty member at the 11/22/13 Meeting in Japan.


**Hair Transplant clinics are using Help Hair Shake and Help Hair® products worldwide.**

**To become an AFR Doctor, please contact us at:**

**info@HelpHair.com**
**ShakeMD.com**