Follicular Transection Rate in FUT in Asians: 15 Years Later

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INTRODUCTION

Follicular unit extraction (FUE) is on the rise and patient numbers are almost approaching those of follicular unit transplantation (FUT) (Figure 1). Many FUT surgeons question whether the transection rate in FUE, which has improved tremendously over the past few years, is too high compared to FUT. Using the S.A.F.E. System (surgically advanced follicular extraction), which is motorized FUE using a dull punch, Harris reported a transection rate of 6.14% (ranging from 1.7%-15%). In another study, robotic surgery produced comparable results with a transection rate of 6.6% (range, 0.4%-32.1%).

Now the gun points to FUT whether the transection rate is even higher. At the ISHRS World Congress and AAHRS meeting, Dr. John Cole challenged the FUT surgeons to study their own transection rates to find out whether it is higher or lower than FUE.

Over the past few years, stereomicroscopes have become the standard for graft dissection in FUT. FUT can be done by blind harvesting. Described below, however, are some of the tools and techniques that decrease follicular damage in FUT harvesting.

One that is available is the Haber Spreader, which claims to have almost no transection. However, the scoring must be deep enough for the device to get inside and spread the incision. The deep scoring is blind, so presumably the transection rate will be higher. Dr. Robert Haber from the United States said a minimum of 2mm scoring is required, however, the depth of 2mm is probably not going to work well on Asian scalp as the skin is tougher and the follicles are longer (5.0-6.0mm).

Dr. Arthur Tykocinski from Brazil uses the Intruder, which requires multiple perforations of the skin 4mm apart, but there is no report of transection rates. Dr. Kamran Jazayeri from Iran uses a spreader device that he designed himself, which, after superficial scoring in the plane of the epidermis, is followed by spreading and pushing apart the deeper skin layers with the spreader device. He reported minimum transection, but again, there is no official study.

Dr. Arturo Sandoval Carmarena from Mexico might be the first to use the hemostat mosquito forceps following superficial scoring of the scalp by opening and closing the forceps repetitively, which spreads the adipose tissue and follicles. Again, there is no formal study on transection.

In 2000, we explored the “open technique in donor harvesting” by the use of skin hooks, and the technique has since been refined with magnification, suction, and 4 skin hooks. The transection rate (before the use of stereomicroscopes) was 1.9%.

Donor harvesting is getting more challenging as we are seeing more patients with repeat hair transplants. This is because the direction of hair follicles in scar tissue is often different and unpredictable. It is also harder to visualize the follicles in the scar tissue during donor harvesting and cutting.

We looked back at the past 15 years on PubMed Central and realized that no new surgeons have studied the...
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Greetings Trichologists,

Welcome to a new year, new editors, and the new look *Forum*. Congratulations to Andreas and Brad on their new “baby.” They have obviously hit the ground running as their first issue is filled with interesting and thought-provoking content.

The attractive new look of the *Forum*, modern and sophisticated from a design standpoint yet with a scientific and professional feel, is far more than a cosmetic overhaul. This update is an important first step in bringing the *Forum* into the digital age, making it mobile friendly with the functionality of an online journal. Toward that end, the Board is currently researching online publishing vendors. The envisioned mobile-friendly site would replace our current friendless “Forum Article Archives Database Search.”

I am thrilled to report that 2017 will bring the ISHRS back to its live surgery roots. Education is one of the three pillars of the ISHRS (along with research and collegiality), and live surgical demonstrations have been an important part of our education legacy. 2017 will bring three ISHRS live surgery workshops:

1. The first is the Orlando Live Surgery Workshop (OLSW), initiated by Drs. Matt Leavitt, Marcelo Gandelman, and Patrick Frechet and co-chaired by Dr. David Perez-Mesa. The OLSW will be back from its hiatus to renew the legacy that culminated in its 20th anniversary conference and will be offered April 26-29 this year.

2. The second opportunity is an all FUE live surgery workshop in Polanicia Zdrój, Poland, that will be held on October 1st and 2nd, just prior to the ISHRS 25th World Congress in Prague. This live surgery workshop, chaired by Drs. Arthur Tykocinski and Jerzy Kolasinski, is entitled “FUE Immersion” to describe its intense coverage of follicular unit extraction surgery. Attendees will be transported from the venue in Poland to nearby Prague for the World Congress following the workshop.

3. The third ISHRS live surgery offering of the year will be hosted by Dr. Sanusi Umar in Los Angeles this October 20-22. This workshop will cover topics related to advanced FUE.

In total, these exceptional live surgery surgical experiences will provide attendees first-rate educational experiences.

As we have in the past, in 2017 the ISHRS will continue to advocate for surgery to be performed by surgeons only. Following up on the theme we launched in Las Vegas at the 24th World Congress of the ISHRS, we recently sent all of you an e-communication that included the badge graphic that we proudly wore in Las Vegas. If you agree with the ISHRS Position Statement on Qualifications for Scalp Surgery (www.ishrs.org/content/qualifications-scalp-surgery), then we encourage you to download the badge graphic and utilize it in your marketing materials and on your website. I was thrilled by the positive response from our members around the world, and I ask you to become a fellow advocate of this critically important message.

While this may all seem like an “ordinary” year for the ISHRS, I am pleased, and very proud, to point out that 2017 marks the 25th year of the ISHRS. This silver anniversary milestone will be celebrated in a number of ways. The majority of these are surprises, which I have no desire to spoil. Suffice it to say that our Silver Jubilee will not go unnoticed and the *Forum* will be a big part of the festivities. Since the ISHRS is not an entity, but, rather, an amalgam of collegial hair restoration professionals, we look forward to honoring all those esteemed visionaries responsible for the birth and growth of our world-leading society. Our celebratory observations will culminate in our Silver Anniversary celebration in Prague at the 2017 World Congress. I look forward to celebrating with you there.

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Co-editors’ Messages

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Dear Colleagues,

I wish you all a happy, healthy and successful new year. To me it feels like we are entering a time of great challenges. This may partly be due to the increased influence of the internet on politics and medical practice.

Over the past decades, our society has become a true global community, and we can be proud to have reached this level of sharing our knowledge and experience in such a professional and friendly way. I am convinced that this will not change. We must think of new ways to demonstrate our expertise to our patients.

I am convinced that hair restoration requires a very individual and personal approach and patient-physician interaction that cannot be replaced by an internet chat or a general automatic algorithm. A lot of experience and skill is necessary for the art of creating a lifelong authentic hairline and adjusting the transplanted hair to preexisting hair. Also, our new colleagues should master all techniques of hair restoration. This is the only way to ensure best outcomes for our patients.

This is our first Forum issue as new editors. I would like to thank the outgoing editors and all column authors who brought the Forum to a new level. In upcoming issues, we hope to focus on common and different approaches depending on patient characteristics and the combination of surgical, medical, and other treatments.

In this issue, Tyng Yuan Tang et al. report low transection rates in their Asian FUT patients with microscopic dissection. It would be interesting to have a half-head study comparing FUE and FUT. I also wonder if the same low transection rates can be expected in Caucasian patients with finer and lighter hair.

Arthur Tykocinski describes his experience with a new FUE punch. There are now several instruments that can improve manual FUE. Timothy Carman describes his FUT scar management, which involves avoiding stretching the neck. This may be even more important in the age of smartphones and yoga. Paul Rose details his study on the difference of the internal and external hair angle. This is important to know as adjustments in tumescence, stretch, hand movement, or the choice of FUE instrumentation may be necessary. In Cyberspace Chat, Robin Unger recounts interesting opinions and practical tips on the use of implanters. So, fortuitously, the material in this issue, largely, matches our members’ requests. We will keep these survey responses in mind as we move forward. While past topics will be revisited and updated, we will also look for and present the latest information.

The literature of science began in 1665 with the near simultaneous publication of the Philosophical Transactions of the Royal Society of London in England and the Journal des Scavans in France. Prior to that, scientists communicated their results by letter and by private publication of books, treatises, or pamphlets circulated among colleagues.1 The idea of using journals to disseminate information was quickly adopted as the standard means of communicating new scientific discoveries.

So, 352 years later, as we advance our knowledge and communicate our results, we welcome ISHRS members around the world to submit material to the Forum. Your content is needed; consider writing about new studies as well as those that build upon earlier results and research. Please help us. We can work together to present the information of our specialty and our Society.

Reference

Notes from the Editor Emeritus, 1996–98

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Every once in a while, an apparent “epidemic” will occur in our practice and we are faced with a profound dilemma.

Over the past year or two, an increase in the number of patches of visible scarring following FUT, and particularly FUE, has been reported. If the condition is becoming more common, is it a result of new surgical techniques or “advancements” in older techniques? Where a session of 1,000 FUs was termed a “megasession” in 1992, it is now routine and operations have expanded to 5,000 FUs in sessions lasting 12 hours or more.

Although the scalp blood supply is rich, it is not without its limits, and these limits vary from one patient to another. The increasing number of FUE “holes,” although tiny, may disrupt the scalp circulation in unpredictable ways, resulting in temporary or permanent loss of donor hair and poor or patchy growth in the recipient zone.

Patches of poor hair growth after transplantation are not normal and are a warning that the scalp blood supply is being pushed close to its limit. The surgeon must “back off” by reducing the number of units per session or by reducing the density or size of the grafts being extracted. There are other possibilities, and, in long sessions, the effects of the epinephrine may be detrimental or the patient may be unusually sensitive to this vasoconstrictor.

It is acknowledged that the pressure for more grafts per session is often patient-driven in a mistaken belief that “more is better.” It is certainly better if all goes well and the patient is spared the inconvenience of a second session. Regrettably, however, the suggestion for more grafts may come, not from the patient, but from the surgeon greedy for a higher fee. Every surgeon must be on the lookout for signs of donor and recipient site stress and, if detected, make appropriate changes to his or her technique.

An interesting question to ask is: Has the condition been around for years, but are the complaints now being “media-driven”? The incentive may be the hope of financial reward via a Class Action lawsuit with no cost to the litigant. An example here is the relatively recently reported “epidemic” of long-term impotence and other symptoms after cessation of finasteride therapy for male baldness (Post-Finasteride Syndrome). Most hair surgeons have prescribed finasteride for hundreds, even thousands of male patients over the past 15-20 years without ever having such a case of permanent impotence reported. The rare side-effect is now acknowledged in the manufacturer’s information.

Another example is Peyronie’s Disease, a common fibrotic condition of the penis said to be present in 1 in 11 males (but who of us inquires or checks?). It was never reported as being associated with finasteride until quite recently. This side-effect is not noted in prescribing information to physicians and is unsubstantiated in the medical literature. Perhaps a case could be made on statistical grounds that finasteride actually protects against the painful symptoms of some cases of Peyronie’s disease by decreasing the turgor of erections.

It is important to question whether a condition is rare and new, and possibly the result of a new medication that was not detected during drug trials. If this is the case, should its use be stopped because of a rare but non-life-threatening side-effect? The unusual side effect should be reported to the manufacturers or regional authorities, but the effect may not bother the patient and the patient may wish to continue treatment with a drug that is otherwise very successful for him.

Another issue to consider with your patients is whether a condition was always present but not distinguished from common male or female androgenetic baldness. Some variants of alopecia areata, frontal fibrosing alopecia, and other scarring alopecies can closely mimic or accompany more common baldness. Triangular alopecia may be present from birth and be accepted as normal, while in rare cases it can develop in adulthood and closely mimic male pattern baldness. Some of the rarer forms of scarring alopecia may be missed, even by specialist dermatologists, and scalp biopsies misread by inexperienced pathologists.

What happens next?

In the event of litigation, many medical defense organizations or pharmaceutical companies may “settle” with litigants to avoid the greater expense of a drawn-out legal battle. An example of this unpredictability of legal costs was the drug Debendox (pyridoxine/doxylamine), which was used successfully for morning sickness in pregnancy for many years. With the thalidomide scandal still in recent memory, Debendox was withdrawn in 1983 after similar lawsuits claiming birth defects were lodged from the UK, Germany, USA, and Australia. Evidence was produced by the famous researcher Dr. William McBride, who had exposed the dangers of thalidomide in 1961. He claimed that Debendox also was causing deformities and demonstrated this in his work with rabbit fetuses. U.S. manufacturer Merrell Dow, sure of its own research, chose to take Dr. McBride before a Sydney Medical Tribunal. The hearing was expected to last 6 weeks, but in fact took over a year in 1988-89. It was shown that some of Dr. McBride’s new evidence had been falsified and the doctor was found guilty of scientific fraud and disgraced.

So where does this leave us with finasteride?

Finasteride has now been on the market for some 20 years and widely used throughout the world in doses of 3.5-7mg per week for hair regrowth, and in even higher doses of 5mg per day for benign prostatic hypertrophy. Most hair loss specialists have had occasional reports of loss of libido that quickly returned after cessation of finasteride. Recommencement on half the previous dose a month later was usually successful, with no return of symptoms. Permanent loss of libido or sexual function are reported so rarely in our practices that we are left with the thought that finasteride might be actually boosting sexual function in our average patient to well above the community norm. Instead of all the current negativity, it would be interesting to research how many men have had their lives improved by finasteride. More hair and less baldness can lead to untold delights while even side-effects of less penile turgor and slower climacteric may have advantages for many couples.
METHODS

Ten South and Southeast Asian patients (Indian, Chinese, and Thai) undergoing FUT were selected for the study and the left 50% of the elliptical strip was analyzed. Only half the ellipse was analyzed due to time constraints and to the fact that the transection analysis process is labor-intensive. Patients who have undergone more than one hair transplant were also recruited in this study, with partial inclusion of the previous donor scar. Transection level was noted and divided into surgical transection, slivering transection, and transection during cutting. All transections were excluded from the final planting of the grafts.

The donor area was first shaved to 1mm and marked using gentian violet solution. The neurovascular bundle was also marked vertically with ink. Donor density was calculated using videomicroscopy. The area was anaesthetized using 0.5% lidocaine with epinephrine followed by tumescent fluid (0.1% lidocaine with 1:300,000 adrenaline) to achieve hemostasis. Next, the donor area was scored superficially using a #10 Swann Morton blade. Four skin hooks were then applied, as pioneered by Dr. Dow Stough, to the exposed superficial dermis, two on each side, for fast and “open” dissection. The hair follicles were directly visualized using this technique. Constant traction of the skin hooks was maintained while the surgeon dissected the donor area using a #15 Personna blade down to the dermal papillae (Figure 2). Pathomvanich (2010) called this the “refined open donor harvesting” technique, which minimized follicular transection.

The surgeon used 4.5× magnification loupes. The skin hooks were constantly repositioned as the dissection continued. If a hair follicle was encountered during the dissection, the follicle could be pulled up and tipped to the dull part of the blade. The bottom of the strip was wrapped in wet gauze to prevent desiccation and was then cut using a #10 blade while being held by the surgeon with the non-dominant hand. This technique also avoids cutting of the neurovascular bundle. By marking the neurovascular bundle, the surgeon is aware not to excise too deeply at this marking.

Once the donor ellipse was taken out, it was wrapped in wet gauze and examined under a 10× magnification stereomicroscope for surgical transections. A note was made of the depth at which transections occurred. It was then handed to the first assistant for slivering. The length and width of the ellipse was measured and the area calculated. The length of the hair follicle was also calculated. The difference between virgin scalp and scar tissue is shown in Figures 3 and 4.

The donor ellipse was then fixed to the slivering tray using two 23G needles. Slivering was carried out using a #10 Swann Morton blade to 1-2 rows of follicular units. Transection rates from slivering were noted using 10× magnification stereomicroscope. Next, the slivers were cut down to follicular units by 7 surgical assistants using the Meiji Stereomicroscope (10× magnification) (Figure 5). The transection rate from graft cutting was noted for the left side of the strip.

The common level of transection from surgical harvesting and slivering was noted and divided into the proximal one-third, middle one-half, and distal one-third.

RESULTS

A breakdown of results by patient is in Table 1. The average overall transection rate was 1.25%. Of this, 0.18% came from surgical transections, 0.28% came from slivering, and 0.79% came from graft cutting. For surgical and slivering transections, 20% were at the level of the superior one-third of the follicle, 6% were at one-half of the follicle, and 74% were at the lower one-third (dermal papilla) of the hair follicle.

A high transection rate (1.31% and 0.98%) occurred at the level of graft cutting on patients with a virgin scalp and high hair density of 89 and 90.5 FU/cm². In addition, a high transection rate at the level of surgical harvesting and slivering (0.54%, 0.6%, and 0.9%) occurred in patients with deep follicle roots (5.5-6mm). Transections tended to occur at the lower one-third of the follicle roots in these cases (74%).

White hairs were the hardest to harvest and cut, as the roots were deeper and hard to visualize. Transection rates at every level were higher in these cases. Four patients in the study were undergoing a second hair transplant. Transection rates were generally lower in these patients although we initially anticipated a higher transection rate over the previous scar tissue because the hair direction was unpredictable and hair follicles were harder to visualize. This is likely due to the low density in the area of the previous scar, which was partially included in the harvested donor ellipse.
CONCLUSION

FUT remains the most popular form of hair transplantation as it allows bigger sessions to be performed in a shorter time without extensive shaving, secures harvesting from the safest donor area, and allows the surgeon to determine graft size including robust “chubby grafts.” Bernstein and Rassman (2001) quoted a 30% greater yield with single blade strip harvesting as compared to multi-bladed knife. That was before high magnification loupes and stereomicroscopes were available.

In the hands of an experienced team, the transection rate is low (1.25%), compared to the estimated 6% in FUE surgeries in similarly well-trained hands, which are also more time-consuming compared to large FUT dissection teams.

We stopped data collection at 10 patients because the results were similar in all the cases, with a median transection rate of 1.22%.

Transection rates were higher during graft cutting in patients with high donor densities, while transection rates were higher during surgical harvesting and slivering in patients with deeper roots. The most common site of surgical transection was at the level of the dermal papilla. Transections were more common at the ends of the ellipse as the incision changed from linear to curvilinear.

Potentially, transections at a higher level (with the distal two-thirds of the lower follicle intact) can be transplanted as stem cells are located in the outer sheath close to the arrector pili muscle near the mid portion of the follicle and move downward towards the bulb area (including the dermal papilla, which is located at the base of the hair follicle).12,13 From the study by Yang et al (2010) and Kim, the rate of regrowth was good, however, other studies have found that the quality of the hair was thinner in nature.14,15 Ergin et al therefore recommended not implanting partially transected hair follicles.12,14,15

With the increasing number of patients undergoing more than one hair transplant and the demands for a single scar, it is important to know how this impacts the transection rate of donor follicles in the affected area. Despite the difficulty in visualizing the scar tissue due to the fibrotic tissue, our findings showed that the transection rate is lower at every stage of harvesting, slivering, and graft cutting in the scar tissue. This is likely due to the low density of scar tissue.

The “refined open donor harvesting” technique allows for direct visualization of the donor site, decreases the transection rate of donor harvesting, and takes only about half an hour to perform. Achieving the lowest possible transection rate is important because it preserves more intact hair grafts for patients. This is crucial because conserving every available fol-

TABLE 1. Results of transection rates in 10 patients of South and Southeast Asians.

<table>
<thead>
<tr>
<th>No.</th>
<th>Ethnicity</th>
<th>Density (FU/cm²)</th>
<th>Surface Area (cm²)</th>
<th>Length of Follicle (mm)</th>
<th>% Surgical Transection</th>
<th>% Slivering</th>
<th>% Cutting</th>
<th>% Total Transection</th>
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<tr>
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<td>Chinese</td>
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<td>19</td>
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<td>Thai*</td>
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<td>0.22</td>
<td>0.88</td>
<td>1.48</td>
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<tr>
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