CONTINUED FROM PAGE 91

INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

May 12, 2017

Mehmet C. Oz, MD, FACS
Columbia University
Director, Integrative Medicine Center
Milstein Hospital Building
177 Fort Washington Avenue, Suite: 7-435
New York, NY 10032 USA

Dear Dr. Oz:

We praise The Dr. Oz Show for sharing an important "buyer beware" message with consumers about hair restoration surgery (May 9, 2017 show). The International Society of Hair Restoration Surgery (ISHRS) has worked diligently to educate consumers and medical professionals about the numerous challenges individuals face when considering hair restoration services, and most abhorrently, the problems of the unlicensed practice of medicine that have recently infiltrated this profession. It is of the utmost importance for patients to thoroughly research potential treatments, procedures, and medical providers.

We are disappointed that you chose not to include the ISHRS on your show after we worked with your producers so closely and provided information that you used. As a result, there were numerous inaccuracies. The ISHRS could have helped you fact-check.

We respectfully ask that you provide updated information to your viewers, perhaps on your website, to correct the inaccuracies and provide consumers with information to help them in their research. You may wish to direct consumers to: www.ISHRS.org. The ISHRS website includes excellent information about how to vet a doctor, what questions to ask, and the Red Flags to watch for.

- The physician interviewed stated that hair transplantation is not considered "a true surgery". This couldn't be further from the truth. Even minimally invasive hair restoration procedures are, in fact, surgery requiring medical expertise. Properly trained and licensed physicians (and where allowed by law in the United States, physician assistants and nurse practitioners who practice within the scope of their licenses), should be the only professionals performing certain aspects of hair restoration surgery. ISHRS Position Statement on the Qualifications for Scalp Surgery
- You mentioned that there is no regulatory body and you encouraged "the FDA, the AMA or the ASPS to get involved." The ISHRS has published the core curriculum and core competencies in hair restoration surgery (*Dermatol Sur*g. 2006; 32:86-90; and *Dermatol Surg.* 2009;3 5:425-428), has and is developing practice standards (*HT Forum* 2015; 25:162-165) and offers continuing medical education activities and fellowship training programs that are 1-year in length. The ISHRS has brought the issue of the unlicensed practice of medicine in hair restoration surgery to the forefront with an extensive outreach to every state medical board, the states' attorney generals, several other countries' ministries of health, and a resolution to the AMA and the CEN (European Standardization Committee). The ISHRS is leading the effort to protect patients.
- The following is an example that we could have easily helped check. The dermatologist who was interviewed stated that "5% minoxidil is not approved for women" so she prescribes the male strength for women. In fact, 5% minoxidil foam for women was approved in 2014.

Again, we support your efforts to educate consumers about using qualified professionals, a message that ISHRS members so fully embrace. We welcome a meeting with you and your staff to further discuss this important topic. And we ask that you inform your viewers and website visitors about the International Society of Hair Restoration Surgery, providing them with a link to our site and information about the valuable resources we offer to help consumers – www.ishrs.org.

Sincerely,

Ken Washenik, MD, PhD, FAAD, FISHRS
President

Victoria Cole, MPA
Executive Director

Ask the Fellows

We are pleased to continue our Ask the Fellows (FISHRS) series in which unanswered clinical questions identified by participants at the Las Vegas meeting are answered by our Fellows. It is a wonderful quick reference to the learned opinions of the ISHRS fellows. Read or keep for future use. Thanks to the Fellows who participate in this ongoing series.

How do you avoid burying grafts when using blunt/hybrid motorized FUE?

James A. Harris, MD, FISHRS

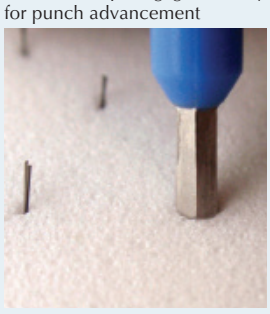
The primary cause of buried grafts when using blunt/hybrid punches is the premature insertion of the punch before it has made a complete incision around the targeted graft; I have called this process "engagement" in previous descriptions of the technique. When the punch is inserted before engagement, the targeted unit is depressed below the skin level, and when the skin incision is completed, the graft is below the surface and buried. There is also the likelihood that the follicles have bent and may actually be inverted in the wound.

The steps to prevent burial due to improper engagement are the following:

1. Apply skin traction opposite the direction of hair growth. This will allow the punch to make contact with the skin in a more positive way and allow the engagement to occur more quickly.
2. Apply pressure of the punch against the skin enough to create an indentation, but DO NOT advance the punch. Allow the punch to rotate and look for the moment the punch tip, the beveled leading edge (Figure 1), has entered the skin completely. When using SAFE System punches, that moment is when the beveled leading edge has entered the skin (Figure 2).
3. Once the leading edge has entered the skin, the punch can be advanced in a smooth fashion to its full depth.

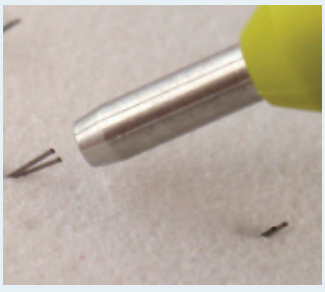
FIGURE 1. Beveled leading edge

FIGURE 2. Tip "engaged," ready for punch advancement



The second cause of graft burial is when the punch alignment is incorrect and the typical burial results from the punch not being acute enough relative to the skin. The adjustment would be to lower the insertion angle for proper alignment (Figure 3).

FIGURE 3. Proper alignment



HOW TO TREAT BURIED GRAFTS

The first step is prevention, and that would be to follow the guidelines mentioned in the preceding description. These are the steps to treat a "buried" graft:

1. Inspect the punch lumen for a complete extraction.
2. Apply pressure with forceps or fingertips to the skin surrounding the site, especially at the lateral and superior positions.
3. Insert forceps or ATOE extractor into the site and attempt to dilate the site and remove the graft if visible.

If these steps all fail to obtain the graft, I leave them *in situ*. In 14 years of performing FUE and hundreds of thousands of extracted grafts, I have only had to remove 2 problematic cysts. The rate of complications from buried grafts is exceedingly small.

Can scarring alopecies be successfully treated with PRP and/or stem cell therapy?

Robert J. Reese, DO, FISHRS

According to the medical textbook, *Disorders of Hair Growth—Diagnosis and Treatment* (2nd edition): "Clinical features of permanent alopecias include inflammatory and noninflammatory changes. In the late stages of permanent alopecia common histologic features are 1) reduced or absent folliculo-sebaceous units, 2) hyalinization or fibrosis of the fibrous tracts, and 3) ectasia or absence of sweat ducts" (Olsen, E.A. Scarring vs. nonscarring alopecia depends on whether there has been permanent destruction of the hair follicle vs. temporary cessation of hair growth. Chapter 4, p. 76, and Chapter 12, pp. 363-364). Based on Dr. Olsen's description, I do not believe that PRP would be useful for reversing or treating scarring alopecia. PRP is NOT regenerative in nature, but has demonstrated utility for wound healing via neovascularization. Some studies suggest that PRP can, to some degree, reverse the miniaturization process occurring in genetically susceptible follicles, but this possible benefit occurs in anatomically normal follicles.

I do think that PRP could theoretically be helpful to treat early stage cicatricial alopecia by directly reducing inflammation. A biopsy would be needed to see if the process is inflammatory vs non-inflammatory. However, I'm not aware of any study where early onset cicatricial alopecia has been treated with PRP injections in this fashion.

Ken L. Williams, Jr., DO, FISHRS

No study has been performed using regenerative human mesenchymal stem cells (hMSC) on scarring alopecias (SA). The sole existing published study on alopecia areata (AA) using hMSCs was a recent study published by Ibrahim (University of Cairo, Egypt).[1] He evaluated the safety and efficacy of the use of autologous bone marrow–derived mononuclear cells (including stem cells) for the management of resistant cases of androgenetic alopecia (AG) and alopecia areata (AA). Six months after stem cell therapy injections, there

was a significant improvement in hair density, confirmed by immunostaining and digital dermoscopy. The study demonstrated the use of hMSCs therapy to be a safe, tolerable, and efficient treatment for the management of AA and AGA.

There are other studies that suggest that PRP may serve as a safe and effective treatment option in alopecia areata.[2]

We are currently conducting two studies in which we hope to demonstrate the potential safety and efficacy of high-density PRP (HD-PRP), AD-SVF, and emulsified adipose-derived stem/stromal cells (ADSCs) in patients with AGA, SA, and AA. Data from these studies is currently unavailable.

References

1. Ibrahim, Z.A., et al. Stem cell therapy as a novel therapeutic intervention for resistant cases of alopecia areata and androgenetic alopecia. *Journal of Dermatological Treatment*. 2016(Aug); 24:1-30.
2. Trink, A., et al. A randomized, double-blind, placebo- and active-controlled, half-head study to evaluate the effects of platelet-rich plasma on alopecia areata. *British Journal of Dermatology*. 2013; 169:690-694.

What criteria do you use when deciding whether to use FUE or FUT, especially in the young patient?

Arthur Tykocinski, MD, FISHRS

We have to consider that nowadays both techniques cover a similar spectrum of patients and there is a personal preference from patients and surgeons that "bias" the decision. Young patients (under the age of 30) are not the best candidates for any technique: they have higher expectations and less predictable hair loss patterns. Considering we can equally offer both FUE and FUT techniques, we have some obvious decisions to make on young patients, such as the following:

- *Family history of Norwood VI and VII*. I would just perform FUT if the goal is maximum coverage. It is safer to stay inside the most permanent donor zone and leave FUE for when the donor area is more defined. If the goal is just frontal coverage and to use short hair and SMP at the back, then FUE is possible. But, in this case, I would try not to maximize the coverage to avoid donor area depletion.
- *Hair length*. For patients who have very short hair, you have to do FUE. It is best for patients that will have complete bald areas of a maximum of 100cm^2. The problem is that identifying future hair loss is difficult and can be tricky. Be aware of future problems.
- *Undefined baldness*. Uncertain borders yield less predictable future. I tend not to do any surgery on patients with undefined baldness. Microneedling every 3 months could be a nice treatment for these patients to get them engaged, along with topical treatments. It is important to wait until the balding borders are defined to proceed with a more global and definitive approach.
- *Small recessions*. Some patients show up to repair parietotemporal recessions they don't like. Some of them are not actually presenting with androgenetic alopecia, but simply a male adult recession pattern and they feel inadequate. Many patients have a hairline that they never liked and now, with further progression of the recessions, they just hate it. Having no antecedents of baldness in the family or signs of miniaturization at the exam (dermoscopy), they are less likely to develop medium to advanced baldness in the future, making them great candidates for FUE.
- *Well-defined bald areas*. These patients are likely to understand our considerations about the real possibilities. They usually present with lower and more realistic expectations, making them adequate candidates. The more I need to cover, especially if they have good laxity, I tend to go with FUT, leaving FUE for a future second or third session. I prefer FUE for patients with smaller needs or lower laxity who don't improve much with two months of scalp massage. Of course, here personal preferences rules!

Keep your distance from young patients who present themselves as arrogant, ultra experts made from the internet. They believe because they are paying you they can treat you as an employee and say to you, "I don't care about the future." Every word you say, they interrupt to question and they act like a spoiled child! Postpone the hair transplant but never say NO to them… I prefer to tell them: "I am not yet sure about the best approach to your case because it is still changing. We should give you a little time to see how it defines." If the patient agrees and stays under your treatment, the patient will become much nicer and more mature. Otherwise, it is better for the patient to look for someone else. I don't think I've lost a patient. I think I've saved myself from a huge headache!

How do you avoid shock loss in the recipient area?

Sharon A. Keene, MD, FISHRS

The issue of shock loss in the recipient area is easy to avoid in patients receiving grafts in areas with no hair. Frequently, however, hair restoration doctors are asked to augment density in areas of thinning. Over a period of years, I have learned lessons about dealing with "preexisting" hair and planning surgery—particularly with the consideration for the risk of shock loss.

Importantly, patients must be made aware of the risk of telogen, or "shock loss," and the possibility it may be permanent. Graft numbers in a given area must be able to "stand on their own" in the event that hairs "shocked" do not grow back. The following are steps I have come to utilize to help reduce the risk of shock loss.

First, I recommend finasteride to all patients with thinning hair caused by AGA. Even those who may not plan to take this long term are advised to use it for at least 6 months to a year after surgery—and to start it at least a month prior to surgery. If they tolerate it for 6 months, many will continue to use it for stabilization. This may help make miniaturizing hairs last at least another growth cycle.

Second, I rarely use epinephrine in any of the tumescent fluid I inject. Although there are no studies to indicate this makes a difference, it seems likely if the trauma of surgery causes shock loss, some of that is due to vasoconstriction from wounding. I therefore avoid the vasoconstricting effects of epinephrine except for local anesthesia. Instead, I use plain saline with anti-inflammatory medication (kenalog).

Finally, recipient sites I create are depth-controlled, sagit-

PAGE 116

CONTINUED FROM PAGE 115

tal incisions in areas where there is preexisting hair in order to avoid under cutting hair follicles and to reduce damage to underlying vasculature. Determining per square centimeter density is akin to walking a tight rope—higher density creates more trauma and probably risks more shock loss; however, placing lower density can still result in loss of miniaturized hairs, and if insufficient grafts have been placed the end cosmetic result will be too thin.

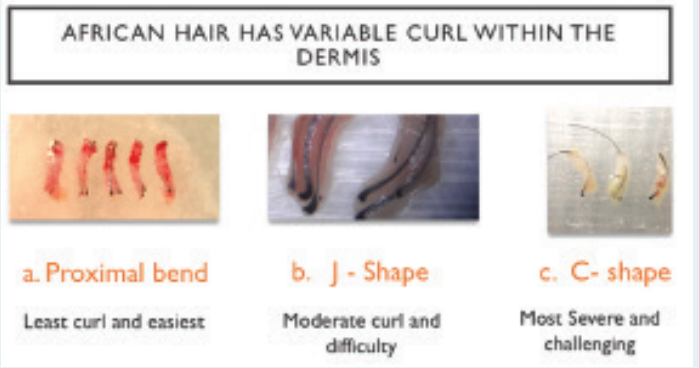
Placement of grafts in areas of visible thinning must always take into consideration the risk that preexisting hairs will be lost—and this may also provide a less visible appearance of change in density. Patients should be counseled about this in advance. Some will be happy to know that they have supplanted healthy hairs for those that were vulnerable. Others will want to plan for higher density despite the increased risk of shock loss in order to ensure improved cosmesis. This is especially true for female patients who seem more sensitive to permanent loss of hair from surgical shock loss.

What FUE techniques are used for patients of African ancestry?

Robert H. True, MD, MPH, FISHRS

Standard FUE techniques must be modified to be successful when treating patients of African ancestry. The main reason is that the hair curl that is observed externally is also present internally (under the skin). The degree of internal curl varies from slight, to a distal hook or "J" shape, or to an extreme proximal curl or "C" shape (Figure 1). All curls are more difficult than straight hair to extract without transection, but the most difficult is the extreme "C"-shaped internal curl.

FIGURE 1. Variable curl of African hair



After trial and error using different techniques over the past 15 years, I have settled on a technique that consistently produces high-quality grafts with minimal transections in African patients (Figure 2). The components include:

1. Using the hybrid trumpet punch and oscillating motor developed by Dr. Jean Devroye.
2. Using 0.9 and 0.95 diameter punches.
3. Recognizing that the internal curl is a continuum of the external curl in direction and shape (Figure 3).
4. Aligning the punch near vertical for initial penetration (Figure 3).
5. Aligning the targeted hairs toward the front of the punch rather than the center (Figure 4). This allows deeper punch penetration.

While sharp punches can be used in African hair, the punches must be inserted very shallowly, especially with C curls, or transection will occur. Thus, more force is required to remove the grafts risking trauma in the process, and the lower portion of the follicles are stripped of any tissue making them more vulnerable during storage and placement. The only way to get around this with a sharp punch is to go "large"—1.1 or greater diameter—and the negative consequence of this is larger scars in the donor area.

FIGURE 2. Typical grafts

FIGURE 3. Proper alignment and orientation with curl

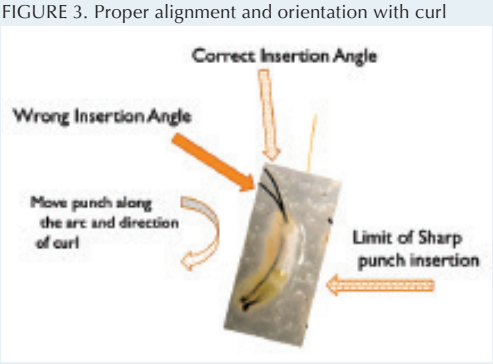
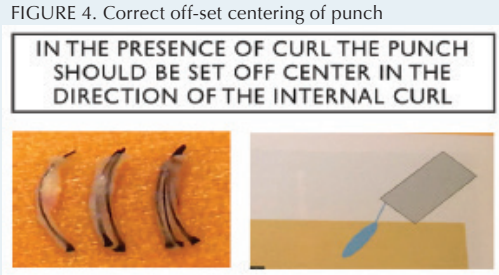


FIGURE 4. Correct off-set centering of punch



With the hybrid, it is typically possible to go 3-4mm deep without transections and the grafts are easy to remove and have tissue protecting the lower portion of the follicles. With this approach, I feel that African patients are usually easy and ideal patients for FUE. We get great healing with the 0.9 and 0.95 punches, and we get a lot of grafts with 3-4 hairs producing great results for the patients.

How do you deal with an unhappy patient?

Lawrence Samuels, MD, FISHRS

It is important to find out why the patient is unhappy. There are times when the unhappy patient begins by what went wrong with his or her transplant. I try not to be defensive, but rather I try to find out what I can do to make the patient happy. Many times, it just involves education about expectations and the time needed to see results. However, there are patients who have specific issues about the transplant that cause them to be disappointed. My response is, "What would you like me to do to correct the problem?"

Typically, the most common complaint is patients feel they did not get the coverage or density they expected. Issues such as pain, folliculitis, itchy scalp, and others can be treated and rarely create an unhappy patient. Once I understand why the patient is unhappy and what he would like, on my part, to remedy the situation, I have to address

a solution in a non-confrontational manner. In the unhappy patient world, they see the solution as a refund, free grafts with another surgery, or both. Again, I try not to be confrontational or defensive, but rather I try to assess what I believe to be the psychology and behavior of the patient. I discuss what I feel would be the best option to make the patient happy. I feel with education and the medical treatment available today, such as PRP, topical follicle stimulators, low level laser light treatment, and Propecia®, I can offer the patient treatments to stimulate growth and provide more time for transplant results. There are times when a small area does not create the results desired by the surgeon, and in my career I have put in a few extra grafts for free, but the norm would be another surgical procedure to create more coverage and density but with some extra free grafts.

Dr. Sam Lam lectures that education is something you tell the patient before the transplant and excuses are what you tell the patient after the surgery. This means the best way to deal with the unhappy patient is to educate the patient prior to the surgery so you avoid the unhappy patient. I have not had an unhappy patient that I could not make happy, however, if I had a situation where a patient was not happy or satisfied, the ISHRS has colleagues who I would not hesitate to call for advice and who would be happy to assist advising me of other options to make the patient happy.

Which complications can I expect from FUE, and which are the most common?

Paul Shapiro, MD, FISHRS

When learning FUE, the most common complication is low graft yield. This can be due to high transection rates, capping, and/or burying grafts.

The physician needs to learn the right angle, correct depth, and sufficient force to apply to the punch to avoid transection. High transection rates happen when trying to get too many grafts for your skill level. Initial surgeries should be kept small, about 500 grafts, and as you get more skilled, continue to increase the number of grafts per session.

Capping occurs when the top part of the graft comes off leaving the rest of the graft behind. Due to fear of transection, the physician does not go deep enough with the punch. It is difficult to eyeball the ideal depth the punch should go. To aid inserting the punch to the correct depth, the physician can put surgical tape around the punch to mark the correct depth. Also, many punches or FUE mechanical devices come with depth limiters. Capping can also occur when the grafts are removed with too much force or in directions not aligned with the angle of the graft. Technicians must be properly trained to remove grafts.

Buried grafts occur when grafts are accidentally pushed under the skin using a dull punch. If left under the skin, these grafts can cause ingrown hairs or cyst formation.

There is the possibility of a smaller percentage of the FUE grafts surviving compared to FUT cases due to the fragility of the grafts. FUE grafts often lack the protective tissue that surrounds FUT grafts, and they are more easily damaged when planting. I tell patients that it is possible to get the same survival as in FUT, however, there is greater likelihood of suboptimal growth in our FUE cases.

Shock loss can occur in the donor region. Usually it is minimal or mild, but occasionally it can be severe and the donor area will look depleted. Severe shock loss is rare, and in the 10 years we have been performing FUE, we have seen it two times. In both cases, all the shocked hair grew back. Shock loss is more common in large cases.

Hypopigmentation can also be a complication. In most cases, the donor scarring of the small punches is minimal and difficult to see. But in some cases, there is hypopigmentation of the scars. The white dots of hypopigmentation will be visible if the donor hair is cut too short. Hypopigmentation is more common when using larger punches and in patients with darker skin.

Lastly, overharvesting also can cause complications. If too many grafts are harvested, the donor site can eventually have a moth-eaten appearance and the advantage of minimal scarring with FUE is lost. Also, in order to get higher yields, it is tempting to harvest outside the safe donor area. This may appear normal at first, but there is the possibility with future hair loss there will be no hair to cover the small round scars from the punch. Another way of overharvesting is to take too many grafts from a small area of donor scalp. When doing a small session, it is tempting to take all the grafts from this small area. That area of donor will grow back thinner than the surrounding donor, and this difference in density can limit how short the donor hair can be cut. It is better to try and spread the extractions out over the entire donor area when possible.

What is the best treatment for frontal fibrosing alopecia, and if and when should it be transplanted?

Bernard Nusbaum, MD, FISHRS

Generally, our treatment protocol for FFA consists of the following three steps:

1. Orally administer finasteride (2.5-5mg) or dutasteride (0.5mg) daily.
2. Use minoxidil foam 5% topically in the morning (it is becoming apparent that follicles that have not been completely obliterated can be "rescued" and some regrowth achieved).
3. Use tacrolimus 0.1% ointment at bedtime.

We try to avoid high-potency topical steroids, such as clobetasol or intralesional steroids, as the frontal hairline skin is already atrophic in this condition. Intramuscular kenalog can be administered in some cases, especially if significant signs of inflammation are evident. As clinical signs of inflammation are often difficult to discern, follow-up should include dermoscopy and also measurements of frontal and temporal hairline position from landmarks in addition to photographs.

There is much debate regarding transplants in these patients. Post-transplantation, grafts can grow well, only to be lost 18-24 months post-surgery, presumably due to disease re-activity. If transplants are considered, I believe there should be a longer time interval (3-5 years) of observation without demonstrable disease activity as compared to the usual 12-24 months empirically recommended for other scarring alopecias. In addition, patients who undergo

PAGE 118

CONTINUED FROM PAGE 117

transplants need to be compliant and continue to adhere to their medical therapy regimen. Lastly, test grafting should be undertaken prior to embarking on a larger transplant session.

How do you prevent postoperative infections following hair restoration surgery?

Steven Gabel, MD, FISHRS

Postoperative infections following hair restoration surgery are rare, and the use of perioperative antibiotic prophylaxis has been debated for years. However, if a patient develops an infection in the transplanted area, it could have devastating consequences on the outcome of the surgical procedure resulting in poor growth, the loss of transplanted hairs, and scar formation. Furthermore, if the patient happens to develop an infection with MRSA, the treatment may require a prolonged course of antibiotics and wound care that the patient and physician were certainly not anticipating or desiring.

To help minimize the risk of a postoperative infection, I have developed specific preoperative and postoperative guidelines that have minimized the incidence of infection in my practice. Starting the evening before surgery, I have my patients remove any make-up and shampoo their scalp for at least 3 minutes with regular shampoo. In the morning prior to arrival at the office, they will shower and shampoo with regular shampoo. When the patient arrives to the office, my staff will assist them in performing a 3- to 5-minute shampoo using 4% chlorhexidine gluconate (HIBICLENS®) being very careful to avoid any contact with the patient's eyes.

Next, we have the patient start oral antibiotics the morning of surgery. If the patient does not have a history of MRSA, then we start a 5-day course of cephalexin. If they have had a history of MRSA, or if I feel they are at greater risk of developing the MRSA infection (i.e., they are a healthcare worker), I will use either clindamycin or trimethoprim 160mg-sulfamethoxazole 800mg. In the operating room, we use a surgical scrub of chlorhexidine gluconate on the donor and recipient sites.

Most importantly, after the procedure, we review how to care for the recipient and donor areas, and stress the importance of hand washing prior to cleaning these areas. My staff and I educate the patient on the signs and symptoms of an infection (redness, pain, drainage), and ask them to report these to the office immediately if they should occur. ■

Meeting Review

Review of the 1st Congress of the Sociedad Ibero-Latinoamericana de Trasplante de Cabello (SILATC) September 27, 2016 | Las Vegas, Nevada

David Perez-Meza, MD, FISHRS | *Benalmadena, Malaga, Spain* | drdavid@perez-meza.com

MISSION ACCOMPLISHED

Finally, after several years of preparations and cancelations, the 1st SILATC (Iberolatinamerican Society of Hair Transplant Surgery) meeting was held in Las Vegas, Nevada, in conjunction with the annual ISHRS World Congress.

Thank you to the ISHRS BOG and specifically to Dr. Sharon Keene (ISHRS Immediate Past President) for believing in my proposal to organize a Global Council Society meeting for the first time during the same week of the ISHRS annual meeting. It was a win-win situation for both societies and history was made.

SILATC Board *(l to r):* Dr. Luis Ortega (Vice President), Dr. David Perez-Meza (President), Dr. Bruno Szyferman (Secretary), Dr. Luis Nader (Treasurer)

I want to thank the co-chairs of the meeting, Drs. Bruno Szyferman, Alejandra Susacasa, and Nicolas Lusicic, and the Organizing Committee, Drs. Luis Nader (SILATC Treasurer) and Erika Elizondo-Nader, for their tireless dedication to the meeting.

We had 80 participants including 17 faculty members; participants came from 15 of the 22 Spanish and Portuguese countries of Ibero-Latin America in addition to the United States, Puerto Rico, and Israel. The speakers presented their lectures and sessions in their own "language," Spanish or Portuguese, and this simple but important detail was one of the highlights of the meeting as the faculty was able to approach the topics without language barriers and we were able to understand one another without any translating issues.

According to the ISHRS's 2015 Practice Census, there was a noticeable increase in hair transplant surgeries in Ibero-Latinamerica from 2012-2014. So, the SILATC members were interested in sharing and learning about new techniques, new concepts, new medications, and new treatments from our region and around the world.

Our hair loss patients in Ibero-Latinamerica include multiple racial groups such as Caucasians, those of African descent, mestizo (indigenous and Europeans), and all mixes that you can imagine. So, with different scalp and hair color, hair characteristics (wavy, straight, curly), face and scalp shapes, etc., and hair loss causes, it is critical to keep those in mind for hair loss treatment and surgical planning.

I organized and divided the meeting into nine modules to discuss all the topics of hair loss, hair restoration, medical and non-medical treatments, research, and complications and difficult cases.

The first module included the initial critical aspect of the consultation, hair loss etiology, scarring, non-scarring alopecias, and ethics. The second module included donor harvesting with strip and FUE techniques. The third module concentrated on the recipient area while the fourth module went over alternative treatments for hair loss including treatment with PRP, the use of autologous fat transplantation, and stromal vascular fraction (SVF) with and without PRP. Two studies about the use of low Level laser therapy (LLLT) for hair loss patients and after wound healing following hair transplant surgery were presented. During the fifth module, clinical cases were presented.

SILATC faculty

The sixth module was organized by Dr. David Perez-Meza and covered the six steps of hair restoration surgery. The seventh module was about difficult cases and the eighth module discussed complications.

Each session and panel included a Q&A from the audience. The meeting always had great communication and camaraderie between the moderators and panelists with the audience.

A Latin cocktail party was the perfect ending to our meeting. Thank you to everyone who participated in the 1st SILATC meeting. ■

A LIFE CUT SHORT
Jonathan L. Ballon, MD, FISHRS
6/11/51—4/30/17

Melvin L. Mayer, MD FISHRS

Jon has been part of the ISHRS family since 2005. He chaired the Basics Course in 2012 and 2013, has participated as a panelist and speaker at multiple meetings, and has served on numerous ISHRS committees. He is known by many of us for his keen mind, and his passion for performing hair transplant surgery with the utmost care for his patients. His great sense of humor to go along with his warm personality will persist in our memories. There has not been a better example of an ethical, quality hair surgeon as Jon.

Jon passed quietly at home with his wife Linda in Alpharetta, Georgia, on Sunday, April 30, after placement of a coronary artery stent the previous week.

Jon graduated with a degree in psychology from Oberlin College in 1974 and received his MD from New York Medical College 1980. Following medical school, he pursued residency training in neurosurgery at the University of Connecticut where he was Chief Neurosurgical Resident his last year and continued as Assistant Clinical Professor from 1987-2004. He told me he was the first surgeon in the state of Connecticut to perform endoscopic cervical discectomies.

It was in 2004 that Jon was accepted by Matt Leavitt, Director of the MHR Hair Transplantation Fellowship, and he completed his training with Carlos Puig, Bob Niedbalski, David Perez-Meza and me. He stayed on with MHR until 2009 when he transferred to Hair Club until 2013 after which he transferred to Bosley Medical. In 2014, he founded Aesthetics Hair Restoration in Alpharetta, Georgia, where he practiced until his death.

Jon had other interests outside medicine. He loved animals, especially dogs. He volunteered at Canine Assistants in Alpharetta to help adapt dogs to become service dogs for the disabled. He was a Founder of "Bikers for the Cure" (to benefit the Susan G. Komen Breast Cancer Foundation). In Connecticut, he had served on the Board of Directors of the Connecticut Affiliate, Susan G. Komen Breast Cancer Foundation.

Excerpts from numerous emails that circulated upon news of his passing magnified the love and respect that we all had for Jon:

Sara Wasserbauer: "Jon was so encouraging. He had a great laugh. He and I would steal each other's jokes to make to patients during hair surgery (It ain't brain surgery… but it is thiiiis close!)

Matt Leavitt: "I am deeply saddened to let you know that we have lost one of our family members. Jon Ballon passed away yesterday. It was unexpected and sudden; we have lost a vibrant part of the MHR and hair restoration community."

David Perez-Meza: "He was a great MHR Fellow, very respectful and always listened to advice. He participated at several OLSWs including his last one in 2014. He was a great human being, great neurosurgeon and hair surgeon. Rest in peace."

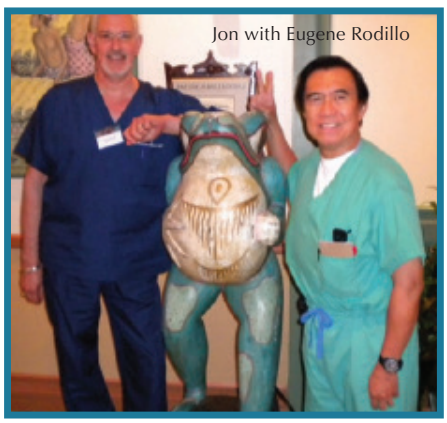
Grant Koher: "I spoke to Jon on Thursday after hearing the news from Valerie and Dr. Rodillo (stent placement). He was resting at home and in good spirits. He and I laughed over past experiences. We agreed to talk later this week about the conference. A great friend, wonderful personality and excellent surgeon. Very sad news. You will be missed by many. RIP my dear friend."

Cary Feldman: "Jon's death is a surprise to us all. Our society and colleagues have lost a very special friend and teacher."

Duncan Simmons: "He was my good friend!"

Victoria Ceh: "I was just talking about him last week at an ACCME conference I attended. We were talking about bringing together different specialties to further medical education, and I was bragging about the ISHRS and its multi-specialty nature. I specifically thought about Jon and mentioned to my small group about our 'neurosurgeon member' who brought insight into transplanting individuals who had previous neurosurgery and titanium skull implants, and how his knowledge and contributions furthered the field. The ISHRS staff loved him, and he will be dearly missed."

Ken Washenik: "I noticed Jon's name on the attendee list for the 2017 Orlando Live Surgery Workshop and looked forward to seeing him. It was always one of his favorite meetings. When I got home, I found out that our field had lost a wonderful contributor and that I had lost a good friend who I had gotten to know through our lives in hair. Patients and doctors loved Jon. He was a warm, engaging man with a giant brain and giant heart. You are already missed my friend."


Jon with Eugene Rodillo

The ISHRS community of hair surgeons is truly a worldwide family that when one is lost, we are saddened. May we all find strength in our professional and personal relationships as well as our faith. ■

Celebrating Its 25th Year: A Look Back to Where It All Began

ISHRS Dallas 1993: An Eye-Opening and Life-Changing Experience for Me and for the World of Hair Transplantation

Robert T. Leonard, Jr., DO, FISHRS
Boston, Massachusetts, USA

I began in the field of hair restoration surgery in 1986 having been trained by the late Dr. C.P. Chambers, a true pioneer and innovator in our field. The problem was that Dr. Chambers, though he trained a large number of currently very famous and respected surgeons, never attended meetings until many years later. I, therefore, had never learned of any formal educational programs in hair transplantation.

Fortuitously, I somehow heard of a new society being created with its first meeting to be held in Dallas, Texas, in 1993. I searched for information about it, which was a lot more difficult in those pre-Google days! I tracked down Dr. Dow Stough and offered my help in organizing the meeting. I became the first Exhibits Chairman for the International Society of Hair Surgeons.

What an exciting meeting for me to meet and to learn from other hair surgeons who utilized very different methods than I had been using. A nice thing for me, however, was to discover that some of Dr. Chambers' techniques I was performing were superior to what I was seeing in lectures.

As a young surgeon in this field, it was truly exhilarating for me to meet and to share ideas with giants in the field! In recalling some of the presentations, particularly about flap methods and scalp reductions, it amazes me that they had been commonplace then and are nearly extinct today. Also, this meeting predated Propecia® and low level laser therapy (LLLT), which are critical today in treating the progression of androgenetic alopecia. Just think about how much they have helped us to provide better results for our patients.

Please note: Sajjad Khan was incorrectly identified as Damkerng Pathomvanich in this column on page 74 of the March/April issue. We sincerely apologize for any confusion this may have caused.

Socially, what an event! I learned what Texas formal was: the upper half of a tuxedo and the bottom half consisting of blue jeans and cowboy boots accompanied by the requisite cowboy hat. To this day, I have the hat and boots I bought in Dallas 25 years ago. Medicine wasn't all that we were practicing in Dallas as we all went to a huge dance hall to learn and to practice line dancing and the Texas two-step… it was a new and exciting experience for this Boston boy!

The incredible and long-lasting result of this meeting was the establishment of the International Society of Hair Surgeons, which was soon changed by the initial Board of Governors to the International Society of Hair Restoration Surgery. I was blessed to have been elected the founding secretary and became president two years later. It has been a great honor and sincere pleasure to be closely involved with the ISHRS for all these years.

Finally, and most importantly, I established lifelong friendships that I dearly cherish a quarter century later. Happy Birthday, ISHRS!

Has the ISHRS changed the world of hair restoration?

Richard C. Shiell, MBBS | *Melbourne, Australia*

PRELUDE

A privately organized meeting with live surgery was convened in Rio de Janiero in October 1992 by Dr. Wagner de Morares. In addition to Mexican and South American participants, he invited an international faculty from the United States, Canada, the United Kingdom, France, Austria, and Australia. During the three days, it became apparent to us all that hair transplantation was not a North American "fad" but of truly international concern. Furthermore, we had board certified specialists from many disciplines mixing on equal terms with earnest transplanters with minimal surgical qualifications or, as in one case, no medical qualifications at all.

FORMATION OF THE ISHRS

Things were moving quickly, and because of an invitation issued in September 1993 to a four-day meeting in Dallas, Texas, 430 including 80 Assistants assembled at the Grand Kempinski Hotel, which I described in the March/April issue of the *Forum* in this same section (The ISHRS: It's Evolution and Foundation, pp. 74-75).

INFLUENCE OF THE INTERNATIONAL SOCIETY

By 1993, traditional 4mm "plug grafts" and "quarter grafts" had virtually disappeared. Minigrafts, dissected with the aid

PAGE 122

CONTINUED FROM PAGE 121

of magnifying loupes from scalp strips, were being planted in ever-increasing numbers per case, and 1,000-1,200 grafts were not unusual. Some surgeons had even adopted Bobby Limmer's meticulous dissection techniques using binocular dissecting microscopes to isolate the follicular units of 1-4 hairs. This later became known as follicular unit transplantation (FUT).

The rapid exchange of ideas in the *Forum* and at meetings plus the success of the megasession techniques helped seal the fate of flaps and scalp reductions, the popularity of which had been declining for a decade.

SPREAD OF NEW TECHNIQUES

Multi-blade scalpel handles for harvesting **donor strips** seemed a great idea. These developed from 2 blades spaced 10-20mm apart to 10 blades spaced 2mm apart yielding 9 narrow strips that could be quickly dissected allowing for rapid graft production. This technique was difficult to master and there was a high follicular transection rate, particularly in the lower strips. Five blades creating four 2mm strips became the most favored compromise. By the mid-1990s and after the formation of the ISHRS, meticulous microscopic dissection of follicular units from a single strip had become the "Gold Standard" and anything less was declared to be *"Follicular Holocaust."*

While this was being debated, follicular unit extraction (FUE) burst on the scene, was refined, and was eventually accepted as an alternative to single strip harvesting. This was a return to punch grafting using punches as small as 0.8mm in diameter with much debate over whether these should be sharp or blunt (or a mixture of both), and hand or machine operated. Everyone agreed that the technique was exceedingly difficult to perform, but some surgeons managed to get their transection rate down from 30% to a very commendable 1.2%. At the same time, the expensive ARTAS® robotic machine was being developed to select and cut the tiny grafts to pre-set specifications. This concept that the difficult selection and extraction of follicular units could be delegated to a machine by surgeons who may not have the ability to do the same procedure by hand in the event of a breakdown is still very much debated.

SOME TECHNIQUES SLOW TO BE ACCEPTED

While some new concepts were grasped and adopted with alacrity, others were slow to be adopted and have faded from the scene. The rapid interchange of ideas within the ISHRS has been largely responsible for this.

Alopecia reduction was quick to gain acceptance from the late 1970s, but within a few years the drawbacks were being recognized. Many attempts were made to circumvent these problems over the next decade. Despite several favorable papers, the Frechet Triple-Flap and Extender techniques failed to attract more than a small group of devotees. This was principally because they were difficult to perform and alopecia reduction had become less popular with surgeons and was being gradually replaced by small-graft techniques.

Implanters were also introduced. Dr. Y.C. Choi of South Korea presented his implanter at the ISHRS inaugural meeting in May 1993, but its use has remained mostly in Asia. Several variants of the Choi device are now available and there have been many improvements. It was recognized early on that implanters enabled fast and efficient placing, and in countries where the placing could be done by non-medical assistants, the constant attendance of the surgeon in the operating room was not necessary at all stages of the operation.

Left to right: Daniel Rousso, Marcelo Gandelman, and Bob Limmer — 1993

COLLEGIALITY

Surgeons performing the same techniques in the same city are competitors for clients, but this does not mean that they should be enemies. On the contrary, by becoming friends and sharing our knowledge at the ISHRS's annual congresses and other meetings, together we can "lift the bar" on standards for the entire city or state. By increasing the acceptance of the procedure, it is possible to ensure that there is more work for everyone. The advent of the ISHRS and regional hair transplant societies brought many rivals together and lifelong friendships have resulted. It is only now, when I have been retired from these meetings these past 10 years and many of my old surgical buddies have died, that I realize how much I gained from my 40 years of hair transplant collegiality. This was particularly the case after the formation of the ISHRS in 1993.

A Little Piece of History

William R. Rassman, MD | *Los Angeles, California, USA*
Russell Knudsen, MBBS, FISHRS | *Sydney, Australia*

The ISHRS was formed in 1993 by a young dermatologist in Arkansas named Dow Stough, and it went head on for the educational market against established competitors from the AACS (American Academy of Cosmetic Surgery), AAFPRS (American Academy of Facial Plastic and Reconstructive Surgery), ASPS (American Society of Plastic Surgeons), and the dermatology meetings. These "Craft Unions" continued from 1993-1995 until the recognition of large sessions of small grafts gained traction. In parallel with this ISHRS growth, the scalp reduction and flap surgeries as a primary treatment for genetic hair loss started to wane. In 1993, new doctors entering hair restoration were confronted with too many surgical options, some requiring more surgical skills than others. By 1995, the recognition that large sessions of small grafts were a reasonable primary surgical treatment for genetic balding moved physician presentations at the meetings more and more in the hair transplant direction. The first major live patient viewing of megasession results was

presented in 1995 in Las Vegas and it changed the field. New doctors from multiple backgrounds found something that they could learn and manage in developing a hair restoration practice. Surgeries that used many small grafts became the easiest and most favored technique because results were better and the surgery was easier to do. These grafts could also be done in anyone's office without a lot of experience. More complicated surgeries that were more difficult, took more experience to perform, and needed to be done in a hospital operating room, like flaps, reductions, and lifts, were done less and less as they fell out of favor. These surgeries are rarely done anymore.

Over the years since, the ISHRS has produced a more well-focused teaching agenda around follicular unit hair transplantation, first by strip and eventually by FUE. The reach of the ISHRS, which started as a more limited U.S.-based organization in 1993, has become progressively internationalized. More doctors from around the world attended these meetings and solidified the role of the follicular unit transplant. In 1995, the ISHRS purchased the *Hair Transplant Forum International* newsletter from O'Tar Norwood for $50,000, which he promptly donated back to the ISHRS to be used for educational purposes. With the ISHRS and the *Hair Transplant Forum International,* hair restoration surgeons worldwide could participate in the technical and aesthetic progression that has driven the field that we know today. ■

Left to right: Patrick Quinlan, Dow Stough, O'Tar T. Norwood, Robert Leonard, and Paul Straub — 1993

Message from the ISHRS 2017 World Congress Program Chair

Jean Devroye, MD, FISHRS | *Brussels, Belgium* | prague2017ishrs@gmail.com

The warm weather arrives in Europe, and the 2017 ISHRS World Live Surgery Workshop and World Congress are coming very soon!

As you know, the World Congress will take place in Prague from October 4th till October 7th 2017, while the World Live Surgery Workshop (LSW) will take place in Polanica Zdrój, Poland, on October 1st and 2nd.

We did receive many propositions for abstracts, posters, videos, and live patient viewing cases.

The subjects of the sessions are almost all chosen. There will be, among others, the past, the present, and the future of cell therapy, a large session of videos, and different sessions about FUE news, innovation and research, concomitant therapy, difficult cases, corrective procedures, storage solutions, implanters, long hair FUT, and FUE.

Particular attention will be paid to the posters. Some of the submitted topics are very likely to be converted into posters. This year there will be a session for the poster authors to defend their topic, and comments on very interesting ones will also be made during the general session.

Last year, the portion reserved for mini-courses for beginners or intermediate levels, workshops, lunch symposia, and discussion table topics was such a huge success that the next meeting will continue in this direction.

Among the featured invited guest speakers, already confirmed are Dr. Dominique Van Neste for a very interesting topic regarding the difficulty to judge the evolution of a hairy zone, and also Drs. Claire Higgins, Tom Dawson, and Ralf Paus.

New techniques will also be described, such as PRP, injection of ACell, and the use of oral minoxidil or of finasteride in solution.

As the FUE session will be largely developed in Polanica Zdrój at the World Live Surgery Workshop on the days preceding the congress, the FUE session will also consist in a summary of the best moments and tips given during the workshop. Another session—FUE News—will be directed by Bob True.

For FUE lovers, I warmly recommend you to reserve your seat for the LSW in Polanica Zdrój on October 1st and 2nd from now on.

For assistants, remember we have a robust Surgical Assistants Program, and this year's chair is the wonderful Emina Vance. There is also a limited-seating Surgical Assistant Core Skills Workshop (hands-on) being led by vice chair Salome Vadachkoria.

We have also on Wednesday many activities: the Basic Courses for beginners, the Advanced/Board Review Course for experts, an FUE Mini Course, SMP Mini Course, and Half-Day Course on a variety of topics.

I am delighted to have you all gather in this wonderful city of Prague and attending the big mass of hair transplantation surgery, marked with a sharing and conviviality spirit. And I am especially delighted to see that year after year, the search for quality is the main purpose of our organisation. ■

Message from the 2017 Surgical Assistants Chair

Emina Vance | *Plano, Texas, USA* | emina@hairtx.com

As we are finalizing the program and confirming the faculty, I am proud to say that we are getting ready for another great meeting. A very important part of creating this year's program is that I'm working with two amazing people, Dr. Ken Williams and Salome Vadachkoria, whose passion for hair restoration and teaching are immeasurable. I am excited to share that we have assembled an amazing faculty from five continents. My hope for the program was to engage a larger international faculty and the response I got from surgical assistants around the world willing to participate and serve as faculty exceeded my expectations.

This year, we are revamping the program so that the workshop focuses on the novice and the main program on the experienced assistants. Over the years, I organized and led many programs and workshops always focusing on beginners. Creating a program that is engaging for seasoned assistants but not excluding the beginners was a challenge. While reflecting on previous meetings and the memorable things I have learned over the years, I realized that it was often the little things that made a difference, such as a new instrument, a different way to sort grafts, or a better way to structure surgical flow. So, this year's program is filled with pearls, the tricks of trade that may not be revolutionary for the industry but could certainly make a big difference in one's practice.

As many of us are visual learners and not everyone is proficient in English, the program is filled with pictures and videos. The first part of the program, called A*ssisting Around the World*, features videos of surgical setups from hair transplant practices in the United States, Brazil, Belgium, the Philippines, and Australia. Imagine being able to visit five offices at the same time! The middle part of the program is titled *New or Improved,* and has physicians and assistants present on various topics relating to a new or a better way of performing our tasks. Finally, the last two sections are *Quality Control* and *Interesting Surgical Cases*. I sincerely believe that the program should be interesting and enriching for all attendees regardless of their skill level, and I sincerely hope that you and your assistants will find it of value. ■

Message from the 2017 Surgical Assistants Vice Chair

Salome Vadachkoria, BBA, MBA | *Tbilisi, Georgia* | salomevadachkoria@gmail.com

I am happy and honored to have a chance to serve as vice chair and lead the Surgical Assistants Core Skills Workshop. I remember when I was a newcomer how welcomed I felt, and ever since the ISHRS has become my family. I am sure that if you have attended an ISHRS meeting at least once, you have experienced this magical feeling of being received by your peers. I will always remember my first visit.

The Surgical Assistants Core Skills Workshop will be offering innovative models created with the leadership of Emina Vance, which has become an evolutionary standard for practical teaching. The workshop is designed to teach students the basics in assisting in hair restoration surgery, and it gives every participant the opportunity to get involved in practical education. The students will receive immediate feedback from experienced faculty members as they learn and practice tissue slivering, graft dissecting, graft placing, and graft removal after FUE harvest. They will learn tips and tricks and demonstrate critical thinking in all of these aspects. As is the theme of the meeting, we will focus on quality control in all of the steps of which the assistant is involved in hair transplantation surgery.

We would like to encourage hair transplant surgeons attending this year's meeting in Prague to bring their assistants, and we encourage you to become more involved in the most important meeting of the year in the field of hair restoration. I am looking forward to seeing you in Prague. ■

Message from the ISHRS 2017 World Live Surgery Workshop Program Chair

Arthur Tykocinski, MD, FISHRS | *São Paulo, Brazil* | arthur@cabelo.med.br

FUE Immersion is on fire! Think unique program—and "go for it"!

Ten surgeries with multiple demonstrations and "revealing" tricks… Not enough? Then check out the program below; it is based on dialogue and discussion panels to present all the shades involved in the FUE technique. There is no absolute truth. There are no gods; no one right way. We are looking to new horizons. Having an open mind is the only way to ensure continued learning and the progressing of any technique. We can all fail, but if we strive to do our best, we will always keep learning.

Now, for the first time, below is a preview of the program. ■

Saturday/September 30, 2017

3:00PM–6:00PM **Basic Course I: FUE Immersion**

- FUE History Overview
- Basic Concepts on FUE and Nomenclature
- Follicular Unit Anatomy and Anchoring Attachments
- Punch Types
- Loupes and Vision
- Donor Area Limits
- Position Yourself: Body and Hand Stable Positions
- Staff and Patients Ergonomics/Comfort
- Incision Techniques and "Feeling" the Attachments
- Follicular Unit Dissection and Depth Control
- Different Extraction Techniques
- Handling the Extractions: Where to Touch, Where Not to Touch and How
- Tips on Extractions
- Complications and How You Avoid Them

6:30PM–8:00PM **Welcome Cocktail**

Sunday/October 1, 2017

7:00AM–8:35AM **Basic Course II: FUE Immersion**

- Donor and Recipient Areas Anaesthesia and Safety; Ring, Nerve Block, and Tips from My Experience
- Donor Area Approach: Higher and Lower Limits, Extraction Pattern and Rate, Strategy in 3 Sessions and Intervals
- Hair Mass Concept and Coverage Index, Math on Hair Mass and Donor Area Evaluation,
- Recipient Area Planning, Tips and Advice

8:45AM–12:20PM **Advanced FUE Immersion WLSW: Day 1**

- Dialogue Panel 1 – We Are Surgeons, Not Gods: Being Humble, Changing Concepts Over Time, Learning from My Mistakes
- Debate Panel 2 – Patient Selection: Ideal FUE Candidate, Is finasteride enough to stabilize baldness? Not a Good Candidate for FUE: Grey Zone
- Debate Panel 3 – Transection Rate: Evaluating and Counting It, Can we rely in regrowth? What Is Acceptable, How to Minimize It
- Debate Panel 4 – Punch Types, Movements and Speed: Go Sharp Manual (with oscillation or without oscillation), Go Sharp Motorised (rotation or oscillation), Go Blunt with Rotation, Go Hybrid with Oscillation, Adding Suction
- Dialogue Panel 5 - Exhausted Donor Areas: Why It Happens, Limits to Avoid It, Treating the Problem, Dealing with Severe Depleted Donor Areas

12:20PM–1:30PM **Lunch**

2:00PM–6:00PM **5 Surgeries; many techniques demonstrated and grafts analyzed; hands-on stations at exhibit tables**

8:00PM **Folk Party in Park**

Monday/October 2, 2017

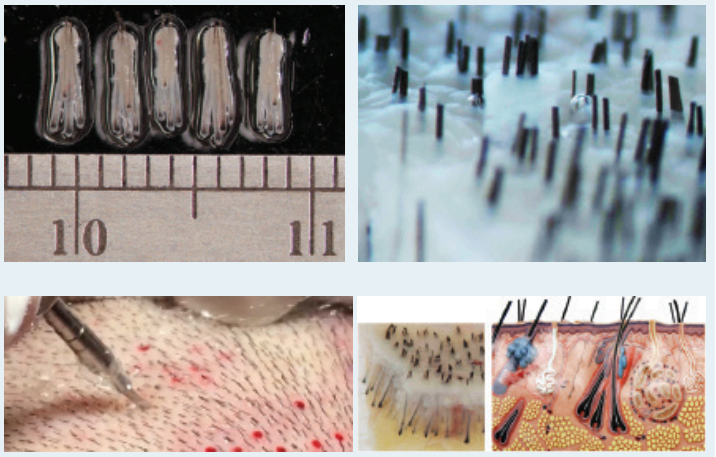
8:30AM–12:20PM **Advanced FUE Immersion WLSW: Day 2**

- Debate Panel 6 – Reasonable Limits: Donor Area Limits in Size and Numbers, Punch Size and Selection, Session Size and Duration, Intervals Between Sessions and Total Number of Sessions
- Debate Panel 7 – Combining FUE and FUT: All FUE Ends in FUT and All FUT Ends on FUE? I Never Combine, Pure FUE, I Mostly Start with FUT, Combining FUE and FUT in the Same Session, Reasons NOT to Combine FUE and FUT in the Same Session
- Dialogue Panel 8 – Beard and BHT: Beard to Beard: Technique and Tips, Beard to Scalp: Technique and Tips, BHT: Sources and Technique
- Dialogue Panel 9 – Implanters Basics: Implanter Concept and Advantages, Different Models, Handling and Adjustments, Using Forceps, Not Implanters
- Dialogue Panel 10 – Graft care: Storing and Handling the Fragile FUE Grafts, Grafts Analysis and Classify on This WS
- Dialogue Panel 11 – New Trends: Hybrid punch, Sharp Implanter Fever, Dull Implanter Technique, Long Hair Preview FUE

12:20PM–1:30PM **Lunch**

2:00PM–6:00PM **5 Surgeries; many techniques demonstrated and grafts analyzed; hands-on stations at exhibit tables**

8:00PM **Finale Conclusion Party**



Classified Ads

Seeking Hair Transplant Physician and Technicians

Anderson Center for Hair in Atlanta, Georgia is looking for a full-time hair restoration physician, and full-time technicians. We are a state-of-the-art, brand-new boutique center. We perform one procedure per day, with emphasis on quality, ethics, and natural results…not quantity. On-the-job training available for physicians. Technicians will require experience, with references required. Outstanding, friendly working environment, salary, benefits, insurance, 401k, vision, dental, etc.

Please email your résumé to: jobs@andersonhsc.com.

Seeking Hair Transplant Surgeon

Los Angeles—Immediate Opening—Top Pay

Busy Los Angeles hair transplant practice is looking for an experienced hair transplant surgeon to join.

Please contact jobs@calihairloss.com or 1-888-930-0554.

ARTAS® System for Sale

Brand-new, state-of-the-art ARTAS robotic hair transplantation system for sale.

This never before used ARTAS system includes: ARTAS robotic system, ARTAS chair, software, controls. Selling price is $225,000. 00 US. ARTAS hair studio training program. Selling price is $40,000.00 US. We are willing to negotiate and accept reasonable offers.

Please call Dr. AL-Saadon at 226-402-1084 or email dr_kalsaadon@outlook.com.

Hair Transplant Clinic/Business for Sale

Hair transplant clinic located in central New Jersey for sale. Clinic has been established for over 20 years; specializes in hair transplant only. Will train new buyer.

Phone: 1-908-380-5080 or email: tango5678@me.com.

25

FUE IMMERSION

DET 1-2, 2017

25TH WORLD CONGRESS

DET 4-7, 2017

2016–17 Board of Governors

2016–17 Chairs of Committees

Global Council of Hair Restoration Surgery Societies

Membership proudly includes:
American Board of Hair Restoration Surgery
Asian Association of Hair Restoration Surgeons
Association of Hair Restoration Surgeons–India
Australasian Society of Hair Restoration Surgery
Brazilian Society of Hair Restoration Surgery (ABCRC)
British Association of Hair Restoration Surgery
French Hair Restoration Surgery Society
German Society of Hair Restoration Surgery
Hair Restoration Society of Pakistan
Hellenic Academy of Hair Restoration Surgery
Ibero Latin American Society of Hair Transplantation (SILATC)
International Society of Hair Restoration Surgery
Italian Society for Hair Science and Restoration
Japanese Society of Clinical Hair Restoration
Korean Society of Hair Restoration Surgery
Paraguayan Society of Hair Restoration Surgery
Polish Society of Hair Restoration Surgery
Swiss Society for Hair Restoration Surgery

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

1. Articles should be written with the intent of sharing scientific information with the purpose of progressing the art and science of hair restoration and benefiting patient outcomes.
2. If results are presented, the medical regimen or surgical techniques that were used to obtain the results should be disclosed in detail.
3. Articles submitted with the sole purpose of promotion or marketing will not be accepted.
4. Authors should acknowledge all funding sources that supported their work as well as any relevant corporate affiliation.
5. Trademarked names should not be used to refer to devices or techniques, when possible.
6. Although we encourage submission of articles that may only contain the author's opinion for the purpose of stimulating thought, the editors may present such articles to colleagues who are experts in the particular area in question, for the purpose of obtaining rebuttal opinions to be published alongside the original article. Occasionally, a manuscript might be sent to an external reviewer, who will judge the manuscript in a blinded fashion to make recommendations about its acceptance, further revision, or rejection.
7. Once the manuscript is accepted, it will be published as soon as possible, depending on space availability.
8. All manuscripts should be submitted to forumeditors@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. Images should be sized no larger than 6 inches in width and should be named using the author's last name and figure number (e.g., TrueFigure1).
12. Please include a contact email address to be published with your article.

Submission deadlines:
June 5 for July/August 2017 issue
July 15 for September/October 2017 issue
October 5 for November/December 2017 issue

Please note new submission address:
forumeditors@ishrs.org

Classified Advertising Guidelines for Submission

To place a Classified Ad in the *Forum*, email cduckler@ishrs.org. In your email, include the text of what you'd like your ad to read. You should include specifics in the ad, such as what you offer, the qualities you're looking for, and how to respond to you.

Classified Ads cost $100 per insertion for up to 75 words. You will be invoiced for each issue in which your ad runs. The *Forum* 2017 Advertising Rate Card can be found at the following link:

http://www.ishrs.org/content/advertising-and-sponsorship

Submit your Classified Ad to:
cduckler@ishrs.org

Calendar of Hair Restoration Surgery Events

http://www.ishrs.org/content/upcoming-events

	DATES	EVENT/VENUE	SPONSORING ORGANIZATION(S)	CONTACT INFORMATION
	MAY 9-12, 2017	University Diploma of Scalp Pathology and Surgery *Paris, France*	University of Paris VI Coordinators: P. Bouhanna, MD and M. Divaris, MD www.hair-surgery-diploma-paris.com	Dr. Pierre Bouhanna, Course Director sylvie.gaillard@upmc.fr
	MAY 18-21, 2017	FUE Europe *Ankara, Turkey*	FUE Europe www.fue-europe.org www.fueeurope2017.com	Dr. John Cole, Program Chair john@forhair.com Dr. Ozgur Oztan, Director drozgur@hlc.com.tr
	MAY 20-21, 2017	7th Annual Scientific Meeting of KSHRS *Seoul, Korea*	Korean Society of Hair Restoration Surgery (KSHRS) www.kshrs.org	kshrs@naver.com
	MAY 27-28, 2017	Society for Hair Science/ ISHR International Scientific Meeting *Venice, Italy*	Italian Society for Hair Science Hosted by Andrea Marliani, MD http://eventi.sitri.it/en/	segreteria@sitri.it vincenzogambino@vincenzogambino.com
	JULY 20-22, 2017	3rd Latin American Hair Transplant Workshop FUE Workshop 2017 *Asuncion, Paraguay*	Paraguayan Society of Hair Restoration Surgery (SPACREC) and Paraguayan Society of Plastic & Reconstructive Surgery (SPACPRE)	http://workshop-latc.com/
*	OCT 1-2, 2017	ISHRS World Live Surgery Workshop *Polanica Zdrój, Poland*	International Society of Hair Restoration Surgery www.25thannual.org	info@ishrs.org
*	OCT 4-7, 2017	25th World Congress of the ISHRS *Prague, Czech Republic*	International Society of Hair Restoration Surgery www.25thannual.org	info@ishrs.org
	OCT 20-22, 2017	ISHRS Advanced FUE Workshop L.A. *Los Angeles, California, USA*	International Society of Hair Restoration Surgery	drumar@dru.com
	OCT 31-NOV 3, 2017	10th World Congress for Hair Research (WCHR2017) *Kyoto, Japan*	The Society for Hair Science Research–Japan http://www.congre.co.jp/wchr2017/	wchr2017@congre.co.jp
*	NOV 16-19, 2017	Hair Transplant 360 Cadaver Workshop & FUE Hands-On Workshop *St. Louis, Missouri, USA*	Saint Louis University School of Medicine, Practical Anatomy & Surgical Education in collaboration with the International Society of Hair Restoration Surgery	Dr. Samuel L. Lam, Course Director Emina Vance, Asst. Course Director http://pa.slu.edu

*2017 meetings that qualify for the ISHRS member educational maintenance requirement

REMINDER

ISHRS full **Members** and **Fellow Members** are required to attend 1 ISHRS-approved meeting every 3 years to maintain their member category.

ISHRS WORLD CONGRESS SCHEDULE

26TH WORLD CONGRESS	27TH WORLD CONGRESS	28TH WORLD CONGRESS
October 10-14 2018 Hollywood (Los Angeles), California I USA	November 13-17, 2019 Bangkok I Thailand	October 21-25, 2020 Panama City I Panama

HAIR TRANSPLANT FORUM INTERNATIONAL
International Society of Hair Restoration Surgery
303 West State Street
Geneva, IL 60134 USA

Forwarding and Return Postage Guaranteed