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FUE Clinical Practice Guidelines

Scalp Micropigmentation: Semantics, Terminology, and Standards

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*Disclosure: Dawn Forshaw is founder of the Finishing Touches Group and has financial interests in companies that manufacture SMP needles, machines, and pigment colours as well as in SMP training.

Scalp Micropigmentation (SMP) is a procedure that is used to create the illusion of shaved hair, stubble, or greater density in hair-bearing areas that have lost hair or require augmentation. It is becoming more popular around the world, and its value to hair restoration surgeons is demonstrated by the ISHRS including it alongside Follicular Unit Excision (FUE) and Follicular Unit Transplantation (FUT) at the Triple Crown World Live Surgery Workshop.

SMP is a relatively new technique and along with the methodology, the terminology is evolving. Although it is different from Permanent Makeup (PMU) and Semi-Permanent Makeup (SPMU), it has evolved from these procedures. Similar to what is happening with the FUE black market, new terms are continually being coined to try and create a business advantage in a competitive market. Therefore, it would be prudent for ISHRS members to educate themselves on the semantics involved in this field and to agree on terminology.

As in other parts of the world, the number of practitioners and salons/clinics offering SMP in the United Kingdom is rapidly increasing. In March 2019, the British Association of Hair Restoration Surgery (BAHRS) recognised the importance of these professionals by creating a specific affiliate membership category for Scalp Micropigmentation Practitioners (SMPPs).¹ In doing so, it was recognised that there were no professional standards for SMPPs in the UK and, even amongst experts in the field, there was confusion about semantics and terminology. A document was therefore required to provide guidance to the BAHRS membership so that communication could be standardised.

The first item to clarify was the relationship between the terms “scalp micropigmentation” and “tattoo” since both are used to identify the same procedure—the implantation of ink or pigment colours into the scalp skin; however, differences have been suggested based on the equipment and medium used.

People use the terms “semi-permanent micropigmentation” and “micropigmentation tattooing” even though the word “micropigmentation” does not yet exist in the Oxford Dictionary and “pigmentation” is classified as a mass noun and defined as “the natural colouring of animal or plant tissue.” Since the words “pigment” and “tattoo” can be used as either a noun or verb, could the word “micropigment” also be used as a noun or a verb? The Oxford Dictionary defines the verb “tattoo” as “mark (a part of the body) with an indelible design by inserting pigment into punctures in the skin.” Although the Oxford dictionary defines “indelible” as “making marks that cannot be removed,” we know from clinical practice that tattoos are not, in fact, indelible because they can be removed with laser treatment. So is it still a contradiction to say “semi-permanent tattoo”?

In the UK, different insurance coverage is required to perform SMP than to tattoo, and insurers make the differentiation based on the equipment used according to the manufacturer’s instructions. This separation will become more difficult with the development of hybrid machines.

In English vernacular, tattooing (as done for artistic body adornment) tends to imply a permanent procedure whereas micropigmentation can be performed to achieve a short-, medium-, or long-term result.

Matters are further confused as tattoo mediums are often called “inks” whereas micropigmentation mediums are called “pigments” or “pigment colours.” However, there is no scientific basis to this. The

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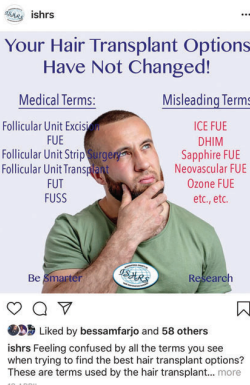
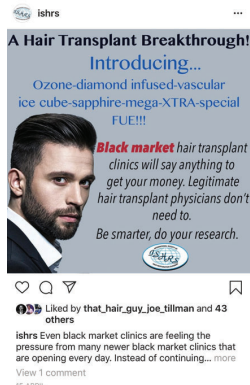
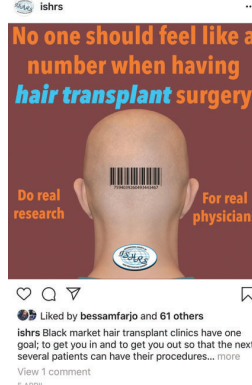
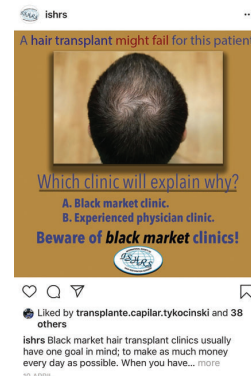
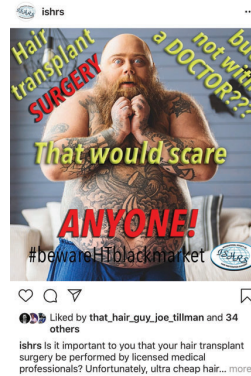
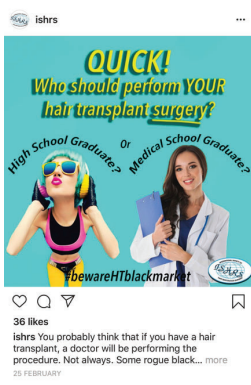
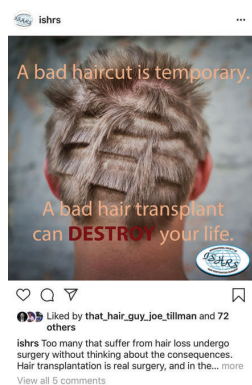
President's Message

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Have you seen these Instagram posts? Please, share them.

If you did, we hope you liked them. But if you didn't, it's OK: these posts are not targeted for you, but for young guys around 25-35 searching for a budget hair transplant. These young men are being massively trapped by unscrupulous clinics and fake influencers...and they are being harmed. Getting their attention is not an easy

task. They live in a different world than most of us! So to get their attention, we have to be innovative, bold, and provocative. It is always risky to get out from the comfort zone, but we decided it was necessary to reach this segment of the public. This is not about my taste or your taste, but rather, the "young" taste. In my opinion, Joe Tillman did a great job creating these Instagram posts. ■



Co-editors' Messages

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Nobody said it was easy. This phrase describes our current situation in hair surgery in several ways.

It applies to the medical part of our specialty. Harvesting viable follicles and transplanting them in a natural, long-lasting fashion remains a challenge. This issue includes the carefully prepared ISHRS's FUE Advancement Committee's submission, "FUE Clinical Practice Guidelines" (page 139). This popular harvesting technique requires a highly skilled hair surgeon to avoid follicle damage and donor area depletion. Several new instruments allow for individual adjustments to hair and scalp characteristics.

But let's keep in mind that FUE alone may not be the optimum solution for all of our patients. A combination with linear excision and microscopic graft dissection (FUT) may increase hair yield and help to avoid overharvesting. This is especially true in patients with a limited safe donor area, fine hair, or fanned-out FUs who require large graft numbers and have no desire to wear their hair short. Every hair surgeon should counsel their patients about the pros and cons of both established harvesting techniques and ideally master both methods.

It is also not easy for us to get our message out: hair restoration requires professional knowledge. A hair transplant done wrong may lead to complications, poor growth, and unaesthetic results—and it will be difficult to correct. Minimizing scars is possible; some hints can be found in Sara Wasserbauer's quiz. Scalp micropigmentation may help to camouflage the scalp and scars, if done correctly.

Let's not forget that androgenetic alopecia is a progressing hair disorder, as outlined in Russell Knudsen's Controversies column. Therefore, hair surgery is only one part of a concise master plan involving hair medications and procedures to stabilize the alopecia. PRP is gaining popularity and there is a scientific base for it, as mentioned in Nicole Roger's literature review. If we want to be more than just hair mechanics, we should provide combination treatments and long-term care.

How do you communicate to the public and patients? What experience can you share with your colleagues? Do you want to publish an article about a talk that you are about to give in Bangkok? Send your contributions to forumeditors@ishrs.org. ■



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Congratulations to the ISHRS FUE Advancement Committee, chaired by Jim Harris, for its submission, "FUE Clinical Practice Guidelines" (page 139). In the 15 years I've been performing FUE, I've moved from a crude Miltex biopsy punch, to sharp

punches, then to dull, hybrid, and trumpet punches. Sharp punches are the least forgiving and require exact aim and depth, while unsharp punches are gentler to the follicles. Because this is a blind procedure, the most important sensation guiding the physician is RESISTANCE. With sharp punches, there is little to no sensation of the resistance that is felt with the non-sharp punches. Minor differences in resistance allow me to make the minute adjustments that guide me to the correct angle and depth. With experience, you can feel the smooth, lack of resistance—like an arm going through a well fitted sleeve—and know you have the correct angle. Angles and depths change in different areas of the scalp and from patient to patient. Small corrections must constantly be made. FUE is certainly the most difficult procedure a hair restoration surgeon performs, and it will continue to be a challenge until a zero transection rate is achieved.

The crucial issue we face is unlicensed assistants performing surgery. The Ohio Administrative Code of the State Medical Board states that "to delegate" means "to transfer authority for the performance of a medical task to an unlicensed person." However, it is illegal to delegate the practice of medicine. There may be jurisdictions where it has been construed that FUE can be delegated, but this has been rightly deemed unethical.

While perusing the internet, I came upon the website of a plastic surgeon who offers NeoGraft hair transplants. He states on his site that his procedure is done by a "certified NeoGraft provider." He also states the procedure will "grow perfectly natural hair," "there is no scarring," and "NeoGraft is non-surgical." In addition, he says that "with NeoGraft, there's no incisions so there's no healing and no hair loss." It's amazing that such misinformation (and poor grammar) is tolerated from a well-trained board-certified plastic surgeon in a major metropolitan U.S. market, who obviously knows very little about hair transplantation. This showcases how the Black Market comes in many forms and is a plague that is rapidly spreading everywhere and to all levels of our specialty.

In Hair's the Question, Sara Wasserbauer tackles another important issue: scarring. It has been my experience that "surgical hair loss" created from hair transplant procedures is the most common type of hair loss, after AGA. Wide donor scars from strip excision (FUT) helped lead to the popularity of FUE. We should all be dedicated to creating as little scar tissue as possible anytime we invade the scalp. We thank Sara for her continued well-written and timely contributions.

Congratulations to Jeff Epstein and Aditya Gupta who will succeed Andreas and me as co-editors beginning in 2020. ■