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Washington Preview

by Paul Cotterill, MD, Toronto, Ontario, Canada – Scientific Program Chairman

Washington, DC — Something for Everyone

Certainly the best reason for visiting Washington, DC, this September will be to attend the biggest, most extensive and up-to-date meeting ever organized by the ISHRS. With the explosion of new techniques, instruments, and scientific investigations evolving, one cannot afford to miss this golden opportunity to be updated on what's happening today. However, considerable effort is also being made to ensure one does not become afflicted with information overload.

In a city with only 543,000 inhabitants, Washington has a lot to offer. In September the summer crowds have thinned out, and one can enjoy the many museums, galleries, and monuments in peace, with an average daytime temperature of 70° F (21° C). Different tours and excursions are being planned to make sure family members touring with attendees are entertained as well.

While many of you have passed through Washington, DC, many times before on business, you may not realize that Washington probably has more attractions for the entire family than most any other city in the USA (and most of them are free!). A walk to Washington's monument Mall (five minutes from the hotel) is an area that will put you on a course for some of the city's top attractions: the Lincoln Memorial, Vietnam Veteran's Memorial, the Tidal Basin, the Jefferson Memorial, the Washington Monument, most of the Smithsonian Institute's museums, the National Gallery of Art, and the Capitol, all on one easy walk. Why not visit the White House while you are there and see what Bill and Hillary are up to?

For children, there is the National Museum of Natural History (kids love the Dinosaur Hall), or the hands-on History Room and Science Room at the National Museum of American History. If you bring children, you won't want to miss the National Air and Space Museum, the Touch Tank at the National Aquarium, or the Capitol Children's Museum where everything is meant to be touched. One of the world's foremost zoos, the National Zoological Park, is also in Washington.

Why not start planning now for you and your family to attend the Washington, DC, meeting in September. Take advantage of what Washington, DC has to offer. ■

Mark Your Calendar!

ISHRS 6TH ANNUAL MEETING

SEPT. 16–20, 1998 • WASHINGTON, DC

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President's message

by Russell Knudsen, MBBS, Sydney, Australia

The tremendous success of the first 5 years of the ISHRS is partly due to the sense of unity and belonging that the Society has managed to achieve. Potentially divisive issues such as credentialing and ethics/advertising are always going to produce differences of opinion, but hopefully these won't fracture the positive benefits that membership has produced.

I spoke briefly about credentialing in the last message, and it is perhaps worth adding that the California Medical Board has recently withdrawn its recognition of the American Board of Cosmetic Surgery exam credential. Other state boards may follow. The American Board of Cosmetic Surgery is vigorously working to revise the situation. The significance of this is that for our North American members, the American Board of Hair Restoration Surgery will have a tough time getting the exam similarly recognized. For our non-American members it shows that at this stage, even this early attempt at credentialing expertise in the specialty of hair replacement surgery is a very difficult task.

So how does a new surgeon ensure that he can demonstrate competence? Members need to ensure that they read the textbooks and journals, attend the meetings, study with acknowledged experts in the field and if possible get hands-on experience so that this background will provide evidence of their seriousness about gaining competence. Developing a good relationship with others in the field is of invaluable help as you can discuss (or refer) surgical problems while hopefully maintaining a good relationship with the patient.

I get regular requests from young physicians for advice about getting started in hair restoration surgery. While it may seem desirable to have less competition for patients and therefore to offer as little help as possible to potential competitors, this may turn out to be counter-productive. It is far better to have competent competitors than incompetent ones. Why? Because bad hair restoration surgery, or bad experiences in hair restoration, do a lot of damage to the credibility of the specialty and may turn many potential patients away. Look in bulletin boards on the Internet if you don't believe me.

I apply the following rule in replying to the request for advice from aspiring colleagues. Are they serious about hair restoration as a surgical art and are they prepared to spend the time to learn the profession properly? I can usually get a good "feel" about the person with their reply and certainly a better idea if they visit me to observe a single case. I then emphasize how difficult it is to both learn, and then to get started, and list for them the necessary learning experiences they need to undertake. This DOES NOT necessitate me taking control of their training. Only the serious will survive, and this is as it should be.

The other issue with competition for patients that continually arises is that of ethics/advertising. I group ethics/advertising together because, without a doubt, almost all complaints about ethical issues and ISHRS members relate to advertising practices. Not all countries allow advertising, but many do (to differing degrees) and this is an area that is potentially very divisive. Each physician, no matter what the working arrangements, is ultimately responsible for the advertising of services. You should personally review, and approve, ALL advertising of your services. You should then apply the following test: would you be happy for your competitor to

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American Society of Hair Restoration Surgery 1998 Annual Meeting – Feburary 1-3, New Orleans

by James Arnold, MD, Reporter-at-large

Welcome to Na-Awlins" was the often repeated refrain by the hotel and the restaurant hosts in this city renown for fun, food, and festival. Although the ASHRS keeps a full meeting schedule, the evening explorations of this unique city added special flavor (Cajun flavors especially) to the conference.

Billed as the First Global Convention on Hair Restoration Surgery, the conference attracted a greater number of attendees than the previous AHSRS meetings. Noticeably missing however were many European participants. The few Europeans present indicated the recent Barcelona meeting, the upcoming Rome meeting, plus the first European Society meeting to be held in May will be adequate to satiate the European appetite for scientific socializing. Still, as our taxi driver said, "There ain't no city like Na-Awlins".

Also, in short supply was new information. It appeared many of the speakers gave their best efforts in Barcelona. Often, the talks given in New Orleans were similar or identical to those given at the earlier meeting. It was great for the attendees who missed Spain but it challenges the reporter looking to break stories on the cutting edge.

The keynote speaker, Walter Unger, MD, touched on many subjects including lasers: results with the CO_2 have been inconsistent. Dr. Unger has decided to cease using the laser for a year awaiting possible new developments, especially with the Erbium laser. He also said, "I don't think the laser has any role in micrografting follicular units."

Graft size

From single hairs to 4 mm grafts, all sizes have a role. To fill large gaps between old grafts, the 4 mm size is most effective. Large grafts give density and the group of patients in his practice with the greatest density have all had large grafts. Dr. Unger stressed the value of large grafts for density with the statement, "I can produce double the density after four sessions of large grafts compared to four sessions of micro- and minigrafting." (A long period of loud murmuring went through the audience as not everyone agreed with this last statement.)

Donor harvesting

"If you are able to minimize transection, use the multi-bladed knife,..." remembering that "...a significant number of the transected hairs will grow."

Graft preparation

"Stay flexible as good results are seen both with and without magnification. The microscope is not the end-all, be-all of hair transplantation."

Recipient site preparation

Dr. Unger advised surgeons to slow down and carefully check angle and direction when cutting sites. Loss of preexisting hair around transplanted grafts is often secondary to damage created by the careless surgeon.

Dow Stough, MD, next summarized his experience with backlights and magnification used for graft preparation. Most of his technicians have adapted to the microscope, but he implied grafts "cut to size" are used frequently. The question of balancing the need to save donor tissue versus the extra time and staff needed with microscopes is often a dfficult question. There is pressure on surgeons to use microscopes since "follicular unit" is the buzzword of the 1990's. The two specific advantages for using the microscope/follicular unit approach are 1) preserving limited donor tissue and 2) as an aid in

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have run this ad?

As a general rule, I believe that advertisements should not be relative. In other words, do not compare yourself with others on competence issues (e.g., "we are the best, the most up-to-date", etc.). State your personal attributes honestly (experience, style of operating) and allow the patient to be attracted by your qualities rather than the denigration of your competitors. Any inference that someone else is incompetent harms both them and you, as patients frequently (and quite rightly) consult more than one surgeon. What you said may be repeated to them. You may be asked to rate your competitors and here, tact is vital. I believe that if you seriously doubt a competitor's competence you should state that you prefer not to comment. The patient usually understands what that means (if you can't say anything nice, don't say anything at all). Being over-anxious to convince a patient that you are the ONLY one who can do the work competently risks you being seen as a salesman rather than as a responsible physician. If your competitors are highly competent, say so. The choice for the patient will usually then depend on who they feel the most comfortable with, and who they most trust. For patients, this is usually more important than the cost. Denigration of competitors does not create trust.

Many members spend large amounts of money on advertising budgets and cost-effectiveness is an issue. Consider that recently a patient came to me via the ISHRS Website. A homepage is a once-only cost of $600 US and provides you with a remarkably cost-effective form of advertising but the transnational nature of the Internet may make the relevance of national advertising regulations unclear. I believe you should seriously look at the homepage offer from the ISHRS. It has been carefully packaged as a member benefit and a significant number of members are already taking advantage of it.

Best wishes to you all. ■

editor's notes

by Richard Shiell, MBBS, Melbourne, Australia

One of the unique features of the International Society of Hair Restoration Surgery is the amazing diversity of our membership. Not only do we have representatives from some 40 countries, but we have doctor members from almost every branch of medicine.

In Japan in the 20's and 30's hair transplantation was firmly in the hands of the plastic surgeons; and with some exceptions it remains so. When hair transplantation was "rediscovered" it was by US dermatologist Norman Orentreich and it then became predominantly a dermatologic procedure in the United States, with plastic surgeons showing little interest for many years. Surgeons and physicians of all persuasions entered the field in the early 70's and hair transplantation "took off." Advances in flaps, reductions, and punch-grafting followed in rapid succession after decades of relative stagnation and almost all of these advances come from those "outside" the hair transplant "establishment" (and often from outside the USA), Argentina, Canada, Finland, France, Australia and Brazil all contributed doctors who brought fresh brain-power and individual national inventiveness to the subject.

The wide divergence of medical backgrounds has never ceased to amaze me and I cannot think of any field which has not sent a representative to Hair Restoration — even from such seemingly unrelated fields as anesthesiology (Bruce Fox, Australia), obstetrics, and gynecology (Masumi Inaba, Japan) and pediatrics (Bob Haber, USA), cardiology (Patrick Frechet, France) and psychiatry (Emanuel Marritt, USA).

Each of these individuals was able to contribute to our newly discovered field by bringing aspects of their specialist training to bear on our problems and each has left an indelible mark with a book or book chapters to posterity.

Reprieve for Alopecia Reduction?

Recently I was able to take up Dr. Mario Marzola's long-standing invitation to observe him perform one of his "M-shaped" reduction procedures. These have been well described in *Forum* and elsewhere[1-2] in the past 12 months.

For those readers not familiar with the discussions of the past 15 years, alopecia reduction has gained a poor reputation because of certain problems inherent to the cosmetic design of the procedure, as well as other problems relating to poor execution in the hands of the uncautious operator. Many attempts have been made to correct these design deficiencies but the new Marzola procedure is, in my opinion, the only one which appears to address all of these defects. This will not prevent poor results in the hands of the injudicious operator of the course, but at least the procedure will not be flawed before you start. The new technique does not leave scars on the crown or temple margins, the two most common causes of complaint with many previous procedures.

The Marzola technique aims at preserving the temporal, occipital, and postauricular neurovascular bundles so that the risk of paraesthesia, severe telogen and tissue necrosis should be very rare events indeed. The other advantage of the new Marzola technique is that, as with the "Mercedes star" or "Rocket ship" designs, the occipital margin of the bald area is drawn up 2-3 cm without leaving a posterior scar as seen after lateral and bilateral reduction procedures. In addition, the temple hairline margin is elevated and not drawn posteriorly, as occurs with the central reductions.

The procedure is well within the capability of most doctors who have experience with alopecia reduction procedures. For best results it is essential to undermine extensively rather than just to the occipital ridge. This means that good lighting, suction, and electrocautery are essential (as well as extra sedation for the patient). The theory of the new procedure is impeccable and the results very impressive. It remains to be seen whether the reduction procedure can regain the confidence of surgeon and patient in the years ahead.

References

1 *Forum:* 1997, Vol. 7, No. 6, 17-22
2 *Amer J Cosmetic Surg:* 1997; 14:167-76

Training Courses

I received information on new training courses during the week — those conducted by NHI in Los Angeles and New York. These are in addition to those run by Dr. Nick Brandy in Pittsburgh, Dr. Dow Stough in Hot Springs and the courses conducted by the ISHRS, WSHRS, and ASHRS.

We know that there are many doctors wishing to enter this field — I get at least six letters and telephone calls a year from Australia alone and other colleagues here get similar numbers (often the same keen inquirers).

The difficulty is in forecasting the future demand. There is no point in having a lot of trained operatives if there is insufficient work to keep them busy or even to maintain their skills. Most inquir-

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ers seem to want to learn hair restoration so they "will have another string in their bow." I think this is an invalid reason. There are so many experienced, but underutilized hair transplant surgeons around now that the casual operator with his poorly honed skills will soon be out of business. So why keep training more of the same ilk?

NHI in its latest newsletter justifies the training of new doctors and assistants with an impressive graph showing the growth of the industry between 1990 and 1994. The figures come from the American Society of Cosmetic Surgery. A growth rate of 38% per year is claimed for that period. NHI then extrapolates this to the year 2000 where they predicted there would be 1.5 million transplant procedures in the United States.

I have a few worries about all this. First, this "growth" does not tally with our actual experience. Business is stationary or declining (except for those who spend vast sums on advertising and promotion).

Second, if there is an increase in hair transplant numbers then it must have been accommodated by a large number of new and inexperienced operators. Past experience has shown that this often results in a rash of poor results, disgruntled patients and a "backlash" in the press about the procedure. This leads to a future downturn in business, not an upsurge as predicted.

Third, and most importantly, I do not know how the ASCS came by these 1990 and 1994 figures. Most of the people active in hair transplant surgery in those years would NOT be members of the Society, so perhaps these figures, like the NHI extrapolation were in the nature of a "guess-timate." I have seen these figures before and have always dismissed them as nonsense but now the matter is serious, as doctors planning a career change may be staking their future on them. The exponential shape of the NHI graph is particularly scandalous. My high school math was a long time ago but I still remember enough to know that two points will give you a straight line graph and in this precarious field of cosmetic surgery even that degree of increase is assuming a lot!

It is wrong to assume, as so many tyros do, that every bald man is secretly wishing he had hair. It is wrong to assume, as some experts have done, that as the surgical standards improve there will be a concurrent rush to have the transplant procedure. (It makes sense but it is not necessarily true!) There are so many other factors which influence the decision-making process:

- The current fad for short hair
- The common expectation that a drug or genetic cure is "just around the corner"
- A burst of bad publicity for the procedure
- Economic factors

In my opinion a stabilization of numbers of transplant surgeons is called for, and better training of those already in the field, not an exponential increase in numbers. Those who wish to argue might start by getting some valid figures on which to base their arguments. I can be fairly certain for the figures for Australia where standards are high and almost every surgeon is known to me personally. I know most of the leading practitioners in Europe and the Americas. There is certainly no evidence of an exponential growth rate in the industry, however much we would like it to be so. The best we can hope for at present is a steady state in '98.