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The Density Issue — A Debate That Refuses To Die

By Bob Limmer, MD, San Antonio, Texas, USA

It is impossible to attend a meeting devoted to hair restoration or to read any significant volume of literature devoted to the subject without coming upon the pros and cons of density relative to the technique used. Classically the argument is made in favor of large grafts producing better density and small grafts reducing lesser densities in the final product. Having converted after 18 years of large graft hair transplantation to the last ten years of small graft transplantation exclusively, I continue to be puzzled at this debate. Perhaps I am simply not seeing what others see on a regular basis.

To answer this question in my own mind, I began to randomly count the actual hair density (hairs per square centimeter) along the mid-portion



Figure 1. Case 1. Frontal hairline restoration immediately post-operatively. 46 follicular unit minimicrografts per square cm.

of the right and left frontal hairlines. Both plug cases transplanted in the standard four-session technique with minimicrograft cases planted in our standard methodology with sessions ranging from one to four sessions were counted. The preliminary findings were described at the International Society of Hair Restoration Surgery meeting in Nashville, Tennessee, in 1996, and subsequently published.¹ Based upon these studies, it is quite evident that equivalent density can be accomplished with minimicrografting techniques with fewer sessions required and a total absence of the "process plugginess"² associated with plug and other larger graft restoration techniques. Since the completion of the data collection for the publication we have continued to randomly collect data on flap, plug, and minimicrograft cases during the last year. This data reflects that our minimicrograft cases done within the last 12 to 18 months average 61 hairs per square centimeter along the first centimeter of the frontal hair restoration zone after one session of minimicrografts consisting of naturally occurring follicular units. After two sessions the average density is 81 hairs per square centimeter. The plug cases average 64 hairs per square cen-

timeter after four plug sessions. Since we have not used the plug transplant technique for the last 10 years, many of these cases counted were transplanted 10-25 years previously. The flap cases (work done by other hair restoration surgeons not in our practice) average 142 hairs per square centimeter.

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President's message

Finasteride — Friend or Foe?

By Russell Knudsen, MBBS, Sydney, Australia



In recent years there has been an upsurge of interest in research into both the cause and the treatment of male pattern baldness (MPB). This will impact our treatment options for our patients and we must think through the implications. As with minoxidil before it, the recent approval of finasteride (Propecia) by the FDA in the United States has led to unwarranted fears among many surgeons that their world is about to end. I believe that finasteride will be a boon to our fields, as was minoxidil.

Historically, before minoxidil, other physicians rarely treated or paid much attention to MPB. We didn't have an effective treatment and patients were usually counseled to put up with it, get a hairpiece, or if they were really keen, consider a hair transplant. Physicians generally knew little about hair transplants and were not always positive advocates of the procedure. Minoxidil changed the picture somewhat because although results were often disappointing, hair restoration surgeons and physicians in general were able to tentatively prescribe something that might work. Thus minoxidil legitimized the medical treatment of MPB for the general medical community. As we all know, 2% minoxidil rarely grows useful hair and even the recent introduction of 5% minoxidil still finds the treatment being only partly effective, its best use being to slow down the progression of MPB. This, however, is complementary to the use of hair restoration surgery in many patients whose hair is thinning. The same complementary role applies to "prescription only" finasteride, which will again emphasize to everyone that MPB is a medical condition that

requires medical treatment.

The previous lack of an effective medical treatment for MPB allowed "hair-loss clinics" to flourish, with many dubious claims about the causes of MPB and the proper management of the condition. As well, there developed a widespread belief that hairdressers and these clinics were the appropriate source of "expert" advice about hair loss. The reputation of the hair-loss industry dropped because of expensive "fringe" treatments selling "hope" to their clients. In my own experience, hairdressers interested in MPB treatment options are usually going bald themselves, and their profession generally doesn't provide competent advice. Hairdressers understandably often see themselves as artists and sometimes respond to advertising slogans from hair-loss clinics and refer clients to them in good faith. As doctors in most countries can't advertise, this provides an uneven playing field.

So how will the partly effective finasteride affect us? I believe it provides a

distinct opportunity for us to utilize a "holistic" approach to MPB. Many patients now coming to our offices to discuss finasteride would not have consulted us otherwise. We have the opportunity firstly to educate them as to the real cause of MPB. Secondly, we can offer them a realistic view of the likely benefits of finasteride. Thirdly, we can properly inform them about modern hair restoration surgery options and their role in the management of MPB. Fourthly, we can demonstrate the complementary roles of finasteride and hair replacement surgery: finasteride may be effective in slowing or preventing further hair loss, which surgery does not. Surgery can provide quality frontal hair growth, which finasteride probably will not.

In addition, finasteride allows us to provide a treatment option to patients who either aren't ready to make a decision about surgery or who are unsuitable for surgery (too young, unrealistic expectations, not enough thinning, too much

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Editor's notes

by Richard Shiell, MBBS, Melbourne, Australia



Redfield Slot Punches

I was pleased to receive some hand-made slot punches from the inventors Gary Hitzig and John

Schwinn over 12 months ago and was quite impressed (see *Forum*, Vol. 7, No. 4, page 18). The punches are now being mass-produced by Redfield Corporation, Montvale, NJ.

I am delighted to report that these packaged and presterilized instruments are even better than the prototypes I tried last year. They come in three different sizes and are incredibly sharp. They cut a neat little trench which mimics the laser slot without the fumes and charring and the huge capital outlay. (The disadvantage is that there is more bleeding and you have small pieces of scalp to remove.)

The punches may be used with new patients but most surgeons will be already committed to minigrafting or the newer follicular unit transplantation. I find the slot punches particularly useful for "topping-up" old plug cases. Slit grafts may be prepared from appropriate-width strips and cut to size to fit the newly created slots. Note that you will have to tailor the width of your slit-grafts because of the varying degree of tissue gape seen with differing scalp tissues. If the grafts are too loose in the slots they may not grow as well because of the delayed oxygenation. Secondly, they will be more easily lost postoperatively because of poor tissue adhesion. If the grafts are too wide you may get graft compression or protrusion.

Many surgeons may prefer to top-up

old plug graft cases with minigrafts or even "follicular family units" but this is an expensive option which many older patients are not prepared to take. The slot-graft option is very much quicker and cheaper without returning to the full-size 4 mm plug and the risk of "donuting".

I recommend these new instruments to all our readers.

Hair and Wool Research

Are you interested in the more esoteric aspects of hair growth? Do you yearn to rub shoulders with the scientists who are attempting to clone human hair and develop new hair growing drugs? If you do, then you cannot afford to miss the Second Intercontinental Meeting of Hair Research Societies scheduled for Washington, D.C., November 5-7, 1998. I know that it is only 7 weeks after the ISHRS meeting, but some things are just too good to miss!! Among the listed speakers are some names familiar to us all — Vera Price, Elise Olsen, and David Whiting, but there are a host of other interesting personalities from academic research institutions in Australia, Canada, France, Germany, Japan, and the United Kingdom as well as the United States.

For further details fax the Secretariat in Vancouver on (604) 669-7083.

Standardization of Terminology

Micrografts, minigrafts, pilosebaceous units, follicular units, follicular family units. Are you increasingly confused with the ever-changing terminology? Well you are not alone. In a field changing as quickly as surgical hair transplantation some confusion must be expected. Those surgeons not quite at the cutting edge of technique development wonder what it is all about and why the new terminology is

necessary at all.

I have great admiration for Bob Bernstein and the 17 other members of our Society who co-authored the upcoming paper on the classification and clinical description of small-graft techniques.¹ I respectfully declined an invitation to join their ranks as I am wary of overdocumentation in what I consider to be still a rather imprecise science — hair transplantation. (You never know when, as President Richard Nixon discovered, your attempts to record every moment of history can be used against you in court.)

Nevertheless, I have considerable sympathy for the aims of the authors in standardizing current terminology. This has been attempted many times before by Unger, Knudsen, Avram, Beehner, Stough, Bondar and others. Never before have 18 eminent practitioners joined forces to lend their considerable experience and prestige to this project. Let us hope that something comes of it on this occasion. Even if we do not all record every nuance in our clinical notes it is essential that we all start using the same terminology in our conversation and writing.

1. Bernstein RM, Rassman WR, Seager, D, et al. Classification and description of follicular unit transplantation and minicrografting techniques. (In publication)

Update on the Rassman Carousel

I am interested to hear from Dr. Rassman about the continued development of his Rapid Fire Carousel. The prototype instruments, he reports, were less than perfect, and the imperfections have caused problems during the shakedown period. Dr. Rassman seems to be taking these problems in stride and is using this experience as a challenge to continue to

improve the instrument before it goes into final production.

He found out, not to my surprise, that there is a requirement to match with some precision, the graft size to the instrument. This is seen in the Choi Implanter, as three size instruments are used to approximate graft size. Dr. Rassman tells me that there will be three size tips supplied with his Carousel, but that the basic Carousel is one size for all graft sizes up to 1.5 mm.

Dr. Rassman believes that the placing speed will be between 15-60 grafts per minute depending upon the surgeon's skills and the patient conditions (bleeding, scarring, etc.). That calculates to 450-1800 grafts per hour per operator (assuming that the loading time is separate from the implantation process). Although that is significantly faster than my present speed, the question we must

ask is does the speed offset costs, or does the instrument add enough quality to justify added costs? Dr. Rassman strongly believes that the Carousel squarely addresses the subject of quality. He believes that the grafts will be delivered with less trauma, less desiccation, and in a shorter time frame. I would have to defer my opinion until I see the instrument in use.

My present planting costs average about US \$100 per 1000 grafts. I would therefore look closely at the instrument costs, once they are announced.

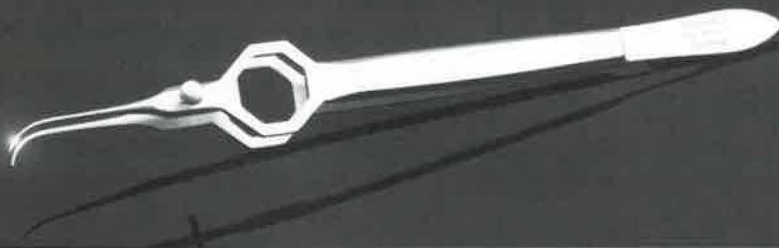
I think that the Rassman Carousel will cause us all to rethink the transplant process. The Carousel has the potential to be the greatest aid to hair transplantation since the invention of lidocaine, but that verdict is still out as either his opinion or mine is pure speculation at this time. ■

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