HAIR TRANSPLANT FORUM INTERNATIONAL

INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

forum

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Hairline Placement: Getting It Right the First Time

Jennifer H. Martinick, MB, BS *Perth, Western Australia*

The idea of an irregularly placed hairline is not new. There have been many attempts over the years, and it has been promoted, but very few surgeons have embraced the concept.

This article presents a formula for creating a natural hairline and thus increasing patient satisfaction.

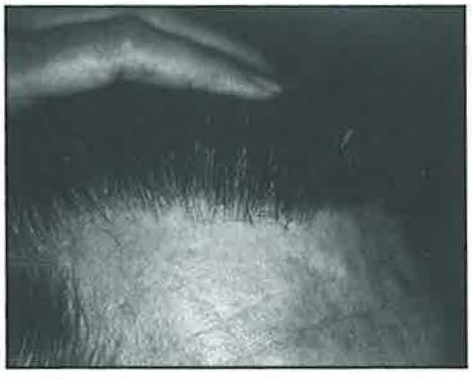
From a patient's perspective, the two most important issues are hairline design and the overall density. Communicating to a patient that he requires 400 grafts to the front hairline when he actually needs 800–900 will lead to disappointment and distrust. The hairline ideally should be completed in one session. It is the surgeon's responsibility to point out that it will still look like a transplant unless the correct density is achieved the first time. This is especially so with dark hair, light skinned individuals.

The natural hairline is a feather zone of sparse, fine, and irregularly placed hair increasing in density from the bald forehead to the denser, coarser hair found on top of the head. Its placement is important as it frames the face and improves the aesthetic appearance lost through baldness. The ideal transplanted hairline is as natural as possible allowing the hair to be combed backwards if desired. Where possible we create a Norwood Class 11 hairline pattern mimicking a mature man's hairline.

Unless there is a cultural or specific job requirement (e.g., actor) for a lower hairline, this placement will suit most men for their whole life. If there is limited donor area, the hairline may be placed higher.

The medical mind that is so neat and orderly is totally at odds with nature, which is random and erratic. In the haste to angle and direct the hairs precisely to give a superior result, we have created hairlines that are now too perfect creating a solid round or bell shape across the forehead.

Often the existing hairs are too coarse and there may even be an obvious pattern in the relationship of the hairs to one another.



50-year-old with no hair loss. (Note irregular nature.)

Excellent hairline creation has become an art form and can be created in the first session.

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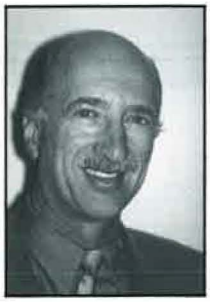
In every issue...

In this issue...

President's Message

Membership Survey Tells Who We Are

Sheldon S. Kabaker, MD *Oakland, California USA*



Sheldon S. Kabaker, MD
Oakland, California USA

You may recall receiving a survey that was mailed to the physician membership on January 22, 1999. The data has given the Board of Governors and the Executive Director's Office some indication of the demographics and background of the membership. Although our response rate was only 24%, we feel that the data collected represents the more conscientious members of our organization and is statistically significant (N=158, Confidence level=90%±6). Our membership is 92% male and 8% female, with a median age of 48 years old. Sixty-two percent of the members practice in the United States and 38% in other countries. Almost 70% of our members are in solo practice, 29% in group practices, and 3% are in academic settings. Sixty-one percent of members have one office, 21% have two offices, with the remainder having three or more offices.

In regard to the number of years performing hair restoration surgery, the responses were quite spread out with 34% reporting 1–5 years of experience, 28% reporting 6–10 years, 14% reporting 11–15 years, 6% reporting 16–20 years, and 18% reporting 21 or more years. Twenty-four percent of the respondents devote all of their time to hair restoration surgery, and approximately 38% devote a quarter or less of their time to hair restoration. Of hair procedures, the average percent of time devoted to hair transplants is 92%, scalp reductions is 4%, and hair-bearing flaps 2%. Our members come from all backgrounds in medicine. The statistics reveal that 31% have a dermatology background, 17% come from general/family practice, 15% from general surgery, 14% from plastic surgery, and 5% from otolaryngology. The remainder (almost 15%) comes from various other medical backgrounds.

To summarize this survey, our membership is international, consisting of mostly solo practitioners with one office, who perform hair restoration surgery by the graft method. Seventy-six percent are not full-time hair restoration surgeons. There appears to be no predominant age group performing hair restoration surgery, and an even distribution of experience with hair restoration.

With this profile in mind, the mission of our organization seems properly directed. We have educational and public information programs geared toward the most frequently performed procedures, catering to all levels of experience and expertise.

So now that we know who we are, where are we going? Our future is dependent on continued public demand for the cosmetic surgery services that we offer. We are at the mercy of economic factors that could change with a recession or increasing competition. There is also the possibility that a change in fashion may occur, such as class VI baldness becoming a symbol of power and beauty (in my dreams). Medical treatment may actually cure male pattern baldness and continued improvement in medical hair restoration may become our downfall. Competition and lower profit margins are forcing some dedicated hair transplant surgeons to perform other cosmetic or medical services. Governmental regulation concerning out-of-hospital procedures will affect the hair surgeon in addition to other practitioners. Board certification for hair restoration surgery or related fields is quickly becoming an issue in the United States and may become an international one.

The ISHRS and the *Forum* will boldly address these and other issues as they arise. We exist to serve as an advocate for the interests of our membership.

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The ISHRS Golden Follicle Award sculpture, as seen on the cover of this issue, was designed by Francisco Abril, MD. Dr. Abril offers for sale, copies of a small bronze hair follicle sculpture (10" high). For more information, please contact: Clinica Dr. Francisco Abril, PO dela Habana, 137, 28036 Madrid, Spain. Phone: 34-1-359-1961; Fax: 34-1-359-4731.

Editors' Messages

Russell Knudsen, MB, BS
Sydney, Australia

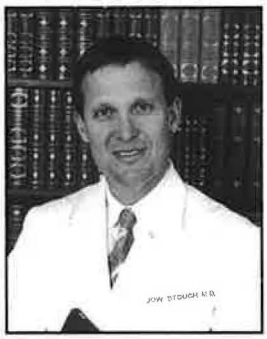
The last issue of the *Forum* had a review of the abstracts from the 2nd Intercontinental Meeting of Hair Research Societies. This *Forum* will contain a review of the meeting by Dr. William Reed. Even though only 31 percent of our members (from the ISHRS survey) are dermatologists, I believe it is essential that we keep current with research in investigative dermatology. It makes us think in the big picture and gives us a better perspective. Patients are better educated than before and often ask us about media reports on "cloning," gene therapy, new drugs, etc.

An added benefit that didn't occur to me is that we have a lot to offer to the investigative dermatologist. I have just returned from the Australian Hair and Wool Research Society bi-annual meeting and was surprised that George Cotsarelis, MD, and Ralf Pauss, MD, who were the principle invited overseas speakers, were intrigued by our experiences with clinical outcomes on a variety of issues. They both felt there should be more "cross pollination" between hair replacement surgeons/clinicians and the investigative dermatologist, microbiologist, and geneticist disciplines of hair researchers.

The lecture by Angela Christiano, PhD, at our Washington meeting was highly regarded by the attendees (her rating scores were spectacular) even though the "hairless gene" has no application to baldness (our principle presenting disorder). Matt Leavitt's March meeting in Orlando featured lectures by Angela, Marty Sawaya, MD, and Maria Hordinsky, MD, who are very well known internationally for their research. This session again rated highly with the attendees for the perspective gained in areas that are not normally within our main expertise.

The introduction of effective pharmaceuticals for the treatment of androgenetic alopecia has changed our field forever, and it is to be hoped that we can continue the convergence of knowledge that occurs when we have these eminent scientists address us. It now appears that "cross pollination" won't be one-way traffic and that we have something to offer the scientists. I would urge all members to take the opportunity to attend meetings of hair research societies. You won't be disappointed.

Russell Knudsen, MB, BS



Dow B. Stough, MD
Hot Springs, Arkansas USA

I appreciate the input from authors who have sent material to Russell and me. We are beginning to accumulate enough articles so that we have a steady supply. Obviously, we need a constant stream of information. I receive a great deal of e-mail nowadays. There is a fair amount of material that exchanges hands among the hair transplant surgeons. E-mail is a wonderful media for a quick exchange of ideas. Russell and I will begin to gather bits and pieces of e-mail that we feel are applicable to readers of the *Forum,* and we will publish these as snippets. Perhaps we will name this section of the *Forum,* "Comments from Cyberspace."

I continue to be in awe of those surgeons who give computer presentations at our meetings. Sometimes I am so impressed with the technology, I forget what the presentation is even about! There is no way that slides can compete with a well-prepared computer Power Point presentation. The one caveat to slide presentations is that the images projected by slides are usually more crisp than what we see in a digital format. I have asked Dr. Tony Mangubat to write an article for the *Forum* stating the advantages of computer presentations. For those of you bold enough to try it in San Francisco, I salute you. Hopefully, I will be among your ranks.

The "Dissector" column is off to a good start. This column is written anonymously. Those of you who want to write an opinion without a name, do so!

Finally, we are developing a glossary of terms that will be presented at the Annual Meeting. A preliminary report on this will be published in the June/July *Forum* by Dr. Bob Bernstein and others. The time for us to standardize terminology for hair transplant surgery is long overdue. This is a project that will require input from our entire society, and I look forward to its completion.

Dow Stough, MD

To Submit an Article or Letter to the *Forum* Editors

Please send submissions via a 3½" disk or hard copy original (faxed copies do not scan easily into the computer), double-space, and use type size 12—or you can submit articles via e-mail. **We would prefer e-mail submissions.**

Submit all North American entries (Canada, USA, Mexico) to:
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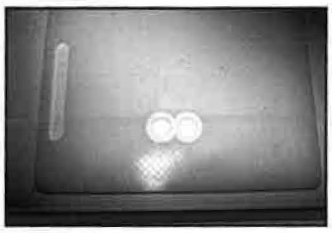
Submerged Graft Dissection

Guillermo Blugerman, MD, and Diego Schavelzon, MD *Buenos Aires, Argentina*

The damage that tissue dehydration causes is well known to general and plastic surgeons who always try to keep tissue damp while dissecting flaps. Dr. Marcelo Gandelman has clearly shown that tissue dehydration is one of the worst dangers, and one of the main causes of loss of graft viability during the process of scalp transplantation. The problem worsens when we work on tiny portions of skin that represent a large surface area exposed to the environment. Furthermore, the atmosphere in the operating room is affected by elements such as air-conditioning, microscope and magnifier lights, and absorbent cutting surfaces often used (e.g., wood).

Center strip, wrapped in plastic, being "slivered."

We are always concerned with keeping tissue wet and cold, which is why we proposed the use of pin cups where tissues are kept wet until the very moment they are inserted. Nevertheless, there is still a critical instant for the follicle: the time it stays on the cutting surface. That instant, by use of the traditional cutting procedure under the magnifier, was reduced to a few seconds but is currently doubled when using the microscope (as per the survey at the World Hair Society Workshop at Orlando in March of 1998).



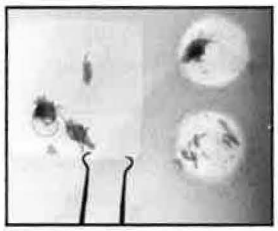
Pincups on cutting board.

Confronted with such problems deriving from the application of new technologies, and in our attempt to put into practice the results of Dr. Gandelman's research, we started to analyze different ways to preserve the temperature and humidity of grafts. After using different saline-solution sprays and discarding them as impractical, we decided to try dissecting the grafts under the saline solution itself. We designed a small tray where we can easily separate the follicular units while keeping them under the liquid. This tray also permits the use of transillumination.

The results were amazing! As well there were six additional benefits:

1. Immersing the tissue in liquid causes a magnifying effect that adds to the magnification already used.
2. The subcutaneous fat cells hydrate resulting in greater contrast between the hair follicle and surrounding tissue. Dissection is therefore easier.
3. The subcutaneous fat cells become almost transparent upon the addition of transillumination.
4. Ergonomics is applied to the tiny grafts as they float in the liquid during cutting, saving time and maneuvers.
5. The number of maneuvers moving grafts is reduced greatly decreasing the risk of crushing, falling, and drying.
6. The system can be adapted to dissection with magnifiers, stereoscopic microscope, or the Mantis microscope.

This new working modality, which aims at saving time and unnecessary maneuvers but mainly to maintain humidity in the grafted tissue, is introduced. All the advantages described above justify the time and effort necessary for the training of surgical assistants in this technique.



Dissection (submerged) in pin cups with backlighting.

Editor's Note (RK)

As usual, Guillermo Blugerman doesn't see problems, rather solutions. Another clever idea from Argentina's endless inventor. Simple, logical, and easy to implement once you have the tray. A petri dish should do the trick.

President's Message

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Your input helps the leadership develop effective programs and policies. Societies such as ours are frequently contacted by the media for background and statistical information, and our ability to provide reliable data helps to firmly establish the ISHRS as the most important organization in the field. This allows us the opportunity to offer our "side of the story" when a print article or broadcasting segment concerning hair restoration is begun. As a member, the provision of our demographic data to your patients during a consult enhances your credibility. An expanded survey was mailed to you in April, and we hope to have a greater response rate. We plan to present the data at the meeting in San Francisco this fall. Please complete this and other surveys when they are sent to you (let's do better than 24%), and contribute your thoughts to the editors of the *Forum*.

Sheldon Kabaker, MD