HAIR TRANSPLANT FORUM INTERNATIONAL

INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

forum

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A View from the Chair

William Lenihan *Los Angeles, California USA* **e-mail: lenihan3we@earthlink.net**

Bill Lenihan is a Los Angeles-based engineer who underwent his first hair transplant surgery in 1985, at the age of 25. His Norwood classification at the time was halfway between II and III. This individual has philosophical problems with the hair transplant industry as a whole. While many of you will disagree with the content of his article, I think it is well worth reading. The Grand Master himself, Dr. Richard Shiell, has composed a brief editorial on Mr. Lenihan's article. Mr. Lenihan has a Web site on which he posts his views on our industry. The more we understand his insights into our industry, the easier it is for us to adapt and change. I believe the reverse is equally true, that is, the more he learns about us, the more likely he is to modify his views. Therefore, publishing his editorial is a win-win situation for all of us. We would very much like to receive Letters to the Editors on Mr. Lenihan's article.

Having spent a few dozen hours in "the chair" (that which the patient sits in during his hair restoration procedures) since 1985, I have been invited by your editor to offer a patient's perspective on today's hair transplantation industry.

After about 30 years of development, where too often the results were poor, the 1990s have seen a vast improvement in the surgical techniques of hair transplantation. Aside from minor debates over the merits of scalp reductions and flaps, solutions seem to be available for many of the problems that plagued this industry. Extensive micrografting, closed donor sites, and microscopic dissection have improved the graft yield and aesthetic results, while nitrous oxide has made the anesthesia experience more bearable for patients. Perhaps cloned hair follicles will soon provide the density that even the most satisfied patients would like to improve on. It appears that the megasession debate—how to get the most grafts done in the least amount of time, without compromising the final results—is the big issue today.

These are the issues, almost always technical, that I see discussed in the medical journals I occasionally come across. As wonderful as this scientific progress is, I have felt for some time that there are other issues that this industry needs to address to improve patient satisfaction. It is these that I want to bring to your attention—headlined by paraphrasing your own literature: "Why wait until you have significant hair loss? Start your hair restoration today!"

In my opinion, the number one issue in reducing the rate of dissatisfied consumers is the evaluation, and selection for surgery, of prospective patients with more weight given to their age and psychological maturity. In February 1997, I published a paper on the Internet that expressed my warnings, caveats, and recommendations concerning hair loss, much of which was about hair transplantation. In the

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In every issue...

In this issue...

President's Message

On Being Paid for *Not* Doing Surgery (Advice Is Worth the Price)

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

I have made it a priority to use this space to address the membership on the progress and workings of the Society. Because we are presently doing well in planning the fall meeting, committee functions are doing nicely, we are in the midst of positive negotiations for a spring live surgery workshop, and we are up to date on Continuing Medical Education (CME) application, I would like to make some points of a clinical and philosophical nature.

Four years ago, I saw a 19-year-old college student referred by a colleague who wanted complete full, dense, undetectable coverage for his then Class 3 hair loss. My analysis was that with his tight scalp, fine hair, and family history, he was heading for a Norwood Class 6 baldness by the time he would be 30. Getting to know him during that 45-minute consult convinced me that his desires could only be fulfilled by a hairpiece. I suggested he also consider a shaved-head style because that style had become popular with young men. Even today, I would still say the same to this particular individual.

This young man was obviously disappointed with the outcome of this consultation, but I felt good about having a part in my physician's advice and also I asked him to return in a few years when he might be accepting of the "natural" mature-appearing result I know I could achieve and he might accept.

The referring colleague was a bit surprised that I turned down such a motivated and solvent patient, but after giving my explanation he seemed satisfied. I must state that he has referred a number of patients since, perhaps acquiring increased respect for my judgment.

The point of this anecdote is that we are physicians first and entrepreneurs second. The welfare of the patient supersedes all other considerations.

Because most of us spend considerable sums on advertising or other forms of marketing, it is hard to resist recouping our investments on those eager and naïve patients who hope to achieve a "completely natural, undetectable, painless, cost-effective, and permanent result," especially if there is a no-charge consultation. Most of you know I personally frown on the practice of a prospective patient being seen by a non-physician counselor without the presence of the operating physician. No matter how well trained, this individual does not have a medical education or license.

I fully understand the need for counselors as part of the initial patient education process in a high-volume practice, but by adding the additional overhead of the counselor's salary to a no-charge consultation, the incentive to "sell" surgery rather than advise the patient becomes stronger.

With our present knowledge of hair loss and its prognosis and the prognosis of our surgical results, we owe our prospective patients the benefit of that knowledge and our collective experience. For that, the patient should pay a consultative fee for, in some cases, the most benefit can be in not having hair restoration surgery. Your time, analysis, and advice has great value and payment for it is in order.

Being compensated for our best work or advice is part of the professionalism that sets the medical profession apart from the business world. You can feel as good about not operating as having a "poster-perfect" result and you do not have to be financially embarrassed by doing so.

Sheldon Kabaker, MD

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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

Paris in the Spring

Touchdown Paris, late spring and it's lovely and warm. I'm here for the 2nd European Society of Hair Restoration Surgery meeting organized by ESHRS President, Patrick Frechet, MD. Wandering the Champs Elysees, viewing the Eye-full Tower, a river cruise on the Seine… it is a struggle to think about spending the days inside a lecture theatre! Seems like everybody thought this would be a great venue because the international faculty is HUGE.

First surprise is how beautiful the venue of the "Hopital de l'Hotel de Dieu" (the hospital of the Hotel of God) is. As one who previously thought hospitals were architectural wastelands designed by people with flat EEGs, I was agog. This hospital would not be a struggle to attend in the mornings. Bit worried about the name though. Not sure it sets an optimistic tone to attending patients. Luckily, the Notre Dame cathedral is right next door.

This conference was very Garlic (sorry, Gaullic) with the registration packet containing printed restaurant menus for the two lunches. The first day we dined on *Blanquette de Lotte a l' ancienne* with *Rix basmati safrane* (with a lovely Sauvignon de Touraine) followed by *Moelleux au chocolat Glace vanille.* The following day was *Saute de Veau printanier* (with a nice Saumer pinot) followed by *Souffle glace au Pamplemousse et Citron Vert.* Lovely, though I thought only allowing 90 minutes for lunch was a bit cheeky. Can't seem to remember what the afternoon lectures were about…

Ah yes, the conference. To say it was well supported would be an understatement. With 128 registrants from 32 countries (of which 17 are European) and 10 live surgeries, it is sure to be the second biggest meeting of the year. Apparently Patrick had planned for, and was expecting, 50-70 registrants! The lecture hall had no air-conditioning and when crammed with people made me think I had attended the European Sauna of Hair Restoration Surgery…

Was there anything new? France, the country that gave us the Biro, has now

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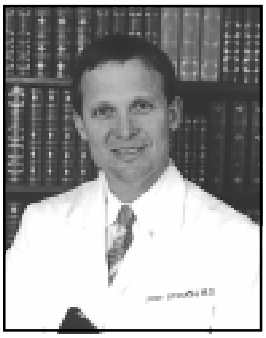

Dow B. Stough, MD
Hot Springs, Arkansas USA

In this *Forum*, you will read comments from Mr. Bill Lenihan. This individual has philosophical problems with the hair transplant industry as a whole. While many of you will disagree with the content of his article, I think it is well worth reading. The Grand Master himself, Dr. Richard Shiell, has even composed a brief editorial on Mr. Lenihan's article. Nearly all industries have some sort of quality control. They achieve this by constant appraisal of their customers' opinions. We all have been the recipients of marketing surveys in industries such as automobiles, hotels, etc. Our industry should be no different. We need feedback from our patients. Using this feedback, we can improve our waiting rooms, phone skills, techniques, patient comfort, and overall satisfaction. Because there will be a wide discrepancy in opinions on any subject, we should look for definite trends. Is Mr. Lenihan off base? Our knee jerk response would be, yes, he is definitely off base. But when you consider he had his transplant at a young age, it is understandable how he has developed these feelings. I have long held a philosophical problem with transplanting individuals before the age of 21. I agree with Dr. Walter Unger's comment, "I don't like absolute rules," but a great deal of our "dissatisfied customers" were quite young when they began their procedures. I also believe that only in exceptional circumstances should we transplant young patients. In the end, the more we understand Mr. Lenihan's insights into our industry, the easier it will be for us to adapt and change. The reverse is equally true, that is, the more he learns about us, the more likely he is to modify his views. Therefore, publishing his editorial is a win-win situation for all. I would very much like to receive your written opinions on Mr. Lenihan's article, and these will be published in future issues of the *Forum.*

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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Unified Terminology

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by the temporal/parietal fringes. The hair on the top portion of the scalp points in a predominantly anterior or anterior/diagonally inferior direction.

Minigraft. A 3-6 hair graft derived from either a single follicular unit, multiple follicular units, or multiple, partial follicular units. Small minigrafts contain 3-4 hairs. Large minigrafts contain 5-6 hairs.

Mini-/Micrografting. A method of hair transplantation that uses grafts containing 1-6 hairs, in groups that do not necessarily correspond to the naturally occurring follicular units. The recipient sites may be either incisions, excisions (tissue removed), or both.

Slit-graft. A 3-6 hair graft derived from either multiple follicular units, or multiple, partial follicular units where the dissection technique specifically attempts to produce a linear arrangement of follicles, or follicular units. This may be further classified into small slit-grafts of 3-4 hairs and large slit-grafts of 5-6 hairs.

Vertex (Crown). The region of the scalp posterior to the vertex transition point where the hair takes on a whorl pattern.

Vertex Transition Point. The point in the posterior aspect of the scalp where the horizontal starts to become vertical. It is the most posterior point of the top or mid-scalp, and generally lies just behind the highest part of the skull. It is the approximate point where the hair changes direction from a predominantly anterior or radially anterior direction, to a whorl. This point is important in that it represents a natural stopping point for the transplant when the reserves are limited and/or the planning conservative.

The Dissector

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question times are needed. Too much democracy in the choice of speaker faculty is not always a good thing. Let them only speak once each unless they have something earth-shattering to say or you have chosen an extra topic for them to speak about. We need moderators who are unafraid and even-handed—who will enforce the rules.

Most experienced surgeons have good ideas but are either too busy or too lazy to put them in print. They are therefore tempted to use their once-a-year speaking opportunity to "get it all out" at meetings. Abuse the privilege and Program Chairmen will remember.

Editors' Messages

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shown us the (new and improved) Boudjema pen. Looks a winner and will shortly be on everyone's Xmas shopping list. As well, Patrick Frechet unveiled another surprise, the Frechet Anchor flap (with 100 cm2 of hair!). I guess this is designed to stop the drift away from using rotation flaps… From Frank Neidel in Germany we learned that the Erbium laser works better than CO2 and, with only 5 microns of thermal damage, is now within 5 microns of being as good as cold steel!

There were many excellent lectures though coordinating live operating theatre crosses with a crammed lecture program proved difficult. Staying on time proved impossible. Even allowing for difficulties with the AV, keeping lectures to their allotted time was an enduring problem. The responsibility for this is shared between the presenter and the moderator. Live operating is a big draw-card, though difficult to successfully incorporate into a big conference when a large lecture program runs in parallel. Perhaps a smaller speaker program together with live operating would work better?

It is increasingly obvious to me the advantage people have when using computer presentations. More visually striking, more audience attention, the ability to graphically demonstrate important points, the list goes on. The increasing sophistication now includes incorporating edited video into a presentation. If you want your lecture noticed, get it on computer. There will be another workshop on this at the ISHRS meeting in San Francisco in October.

The social program was, as you would expect, fantastic. Cocktails in the exquisite Town Hall one night followed by a black-tie dinner at the Ritz Hotel the following night. As Anne didn't come with me to Paris, this almost caused a divorce. A truly memorable few days! Bravo, Patrick.

Russell Knudsen, MB, BS