The European Society of Hair Restoration Surgery (ESHRS), created to promote science and friendship amongst doctors, entering its fourth year of existence, is at present the largest European society, gathering over a hundred physicians, amongst whom many of the best specialists in the field, known world-wide.

The European Society of Hair Restoration Surgery has welcomed European as well as International physicians and will continue to do so, hence offering the largest possibility of communication between members to maintain and promote high standards of practice by organising a congress and live workshop in a major European city each year.

During last year's annual congress, held at Istanbul, Doctors from the five continents met to share their experience and expertise and enjoy the exotic social events, cruising on the Bosphorus, dining and dancing in a historic Ottoman Palace.

This year the venue for our congress and live workshop will be Barcelona, famous for its festive atmosphere, lively ramblas, its museums and unique architecture by Gaudi; and the near-by famous seaside resort of Sitges, a medieval village overlooking the blue Mediterranean sea.

ESHRS members benefit from a special rate for their inscription to the congress. They shall be receiving regularly ESHRS' newsletter. A program of tuition and accreditation for ESHRS members is presently being established.

The quality of our society lies upon the scientific and ethical qualities of our members and their financial support is essential to move ahead together and progress.

If you are also interested by hair restoration surgery and if you are looking for a society which intends to support as much as possible its members you are most welcome to join us.
Dear friends and colleagues,

Next Congress will be held in Barcelona, in the year 2001. I have the honour of presiding the event. Besides, we’re organizing scientific sessions, where more than sixty Faculty Speakers from all over the world have already confirmed their attendance. Moreover, we are preparing a Live Surgery and Didactic Workshops and a Program for Medical Surgical Assistants as well. We hope all that will make stronger our Society, so it will become a reference for all those who are devoted to the surgery of baldness.

The scientific societies are good to increase the prestige of all the medical members of this Society and I believe that is fundamental for our Society the international prestige so that our techniques are much more popular and have total credibility.

I hope that the edition of the ESHRS Newsletter allows us to exchange ideas, to improve our procedures, so we get better results.

Sincerely yours.

PRESIDENT’S MESSAGE

Dr. Ramon Vila-Rovira
ESHRS President

Exchange, contributions and support between ESHRS members

This is the first newsletter of ESHRS. As such dear member I wish you success and pleasure in life and all the improvements possible in your work.

The aim of this letter is to be a means of dialogue, of exchange of contributions and support between ESHRS members.

We shall write and explore every aspect of our hair transplant activity and provide a support for those of our members who wishes to introduce or develop their ideas.

I hope to hear from you as early and as soon and as frequently as possible. All the interest of this newsletter relies upon the energy that every one is willing, to put into.

With my warmest personal regards.

EDITOR’S MESSAGE

Dr. Patrick Frechet
ESHRS Founding President

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EDITOR’S MESSAGE

Dr. Patrick Frechet
ESHRS Founding President
More survival and faster growth in hair transplantation

By Dr. Nicolas A Lusisic and Alejandra Susacasa

INTRODUCTION
We all know the benefits of cold in the preservation of live tissues to be transplanted. In order to achieve more vitality in grafts, we designed and implemented a permanent cold chain from the moment the follicles are removed until they are transplanted. For that purpose we created and use special tools.

TOOLS AND METHODS
In our daily practice we used to preserve the strip in iced saline solution, after which the grafts were placed on the patient’s forehead, thus exposing them to both the direct heat from the headlights and the patient’s body temperature. These heat sources caused rapid macroscopic changes such as dehydration, stiffness, change in color etc., turning many grafts into non-viable tissue.

In order to keep a chain of cold as well as of permanent hydration, we began using a set of piled-up acrylic trays containing saline solution and with ice in the central compartment. Although the grafts remained cold longer, the chain was interrupted at the moment of transplanting them. This caused us to design a hair band-shaped device, made of vacuum-sealed polypropylene and filled with a special gel. Such hair band would fit the patient’s forehead and hold the grafts keeping them at a low temperature, thus countering the patient’s body temperature and the heat from the headlights.

RESULTS
In the last two years we have implemented the cold chain in hair transplantation procedures with the following results:
1. Less or no telogenous effluvium
2. Immediate growth of transplanted hair
3. More follicular survival

It is worth pointing out that using this method has not increased costs significantly, neither has it prolonged surgical time or modified the percentage of complications inherent to the method.

CONCLUSION
In our experience, preserving the cold chain has proved to be highly beneficial to increase survival of transplanted follicles, thus achieving better and faster results.

SUMMARY
Knowing the positive effects of low temperatures on tissues, we decided to implement a permanent cold chain in hair transplantation procedures and assess the results. In order to carry out the experiment, we used a set of piled-up trays with ice in the central compartment, and created a device filled with special gel to keep temperatures low and to hold the grafts during transplantation. After using the method for two years, we were able to verify less telogenous effluvium, faster growth and better results due to the increase in graft survival prior to transplantation.

Laser assisted autologue hair transplantation with the Er:YAG laser (LAAHT)

By Dr. Frank G. Neidel
(Düsseldorf - Germany)

The introduction of modern CO₂ lasers opened up a new era also in the field of autologous hair transplantation. The initial euphoria was followed by phases of gaining experience and comparing laser technique to the conventional cold steel method. Meanwhile scientific investigations are being made and visual comparisons become possible.

Laser treatment provides both advantages and disadvantages. In any case, keeping the risk as small as possible should be the criterion for the decision of which technique to be applied for the patient. The application of CO₂ lasers should in any case be left up to the proficient hair surgeon. Basically, this method always involves the risk of confluent burns. Also, the implantation technique is sometimes very traumatizing to hair follicles. Today, most of the hair surgeons are still employing the cold steel technique.

Because of the risk involved in laser hair transplantation with the CO₂ laser, we were looking for a system less risky both for physician and patient. We have found it in the Er:YAG laser system. It does not operate in a vaporizing but ablatting manner because of its technical characteristics. It is therefore also described as cold laser.

To verify the good results obtained in dermatological areas also for hair transplantation, first we applied holes at different energies in vivo on a patient for a scalp reduction treatment. Subsequently, we examined the holes histologically. The thermal damage of the holes walls was range between 10 and 50 microns and thus less than that caused by CO₂.

Afterwards, we applied holes of equal diameters on a patient both by micropunches in cold steel technique and with the Er:YAG laser for comparison. The implantation turned out to be simple and non-traumatic. Bleeding was slightly less than with cold steel technique and slightly more compared to the CO₂ laser treatment. In postoperative phase, wound healing was absolutely comparable. Particularly, long lasting erythema as is known from CO₂ lasers could not be observed.

In conclusion we think the Er:YAG laser represents the best alternative to cold steel technique. It will supersede the CO₂ laser in the field of hair transplantation in the next few years.
“Minimal Depth Transplanting” and the Use of “Tense Tumescence” in the Recipient Area

By Dr. Michael L. Beehner
(Saratoga Springs, New York - USA)

One of the most important limiting factors in the growth of hair is the blood supply of the scalp which supports the transplanted grafts. Because our transplant sessions are larger today, with many grafts being used, it is important to protect that blood supply in every way possible.

The network of larger vessels that supplies blood to the scalp resides in the deep subcutaneous layer and sits just above the galea layer. The idea behind “minimal depth transplanting” is to make the recipient sites so that they penetrate only to a limited depth, which doesn’t damage these vessels. This concept was first mentioned by Dr. Edmond Griffin in 1992, and again by Dr. Jim Arnold in 1998.

Because the scalp is relatively shallow in depth, it is very easy to repeatedly cut into these vessels if no special precautions or techniques are used. I proposed in the Hair Transplant Forum International in January of 1999 that the best way to insure that these recipient sites avoid these deeper vessels is to inject a saline solution into the dermis and upper half of the subcutaneous tissue. Figure A shows a cross-sectional view of a relatively thick scalp, which has just been removed in a scalp reduction. The left side of the tissue shows its normal depth, while the right side shows the dramatic increase in depth of the subcutaneous layer achieved after injecting this layer with saline / epinephrine. In order to achieve this injection, much pressure is required, due to the natural resistance of the tissues. It is my firm belief that, when tumesced fluid goes into the scalp with little or no resistance, it is being deposited beneath the galea and does nothing to prevent cutting through the blood vessels I mentioned above. I find it helpful to use a Byron Disposable 10cc syringe and a 25g needle to inject with (Figure B). Because of the high pressure generated, it is necessary to actually keep the fingers of the left hand around the hub of the needle, to prevent unscrewing the needle. There should be some resistance to this injecting if one is at the proper depth. Also, while injecting, one should notice the skin blanching from the epinephrine (we use 1:100,000 concentration), and obviously one can feel the skin becoming very firm and thickened with this. In limiting the depth of the recipient sites, it helps to, employ some sort of “brake” for preventing overly deep penetration of the needle or punch being used. Figure C shows a needle holder being used to limit the depth of a NoKor needle. It is being held next to the injected tissue that was shown above, in order to show that it only penetrates into the upper half of the subcutaneous layer. We use the Super Punch from A to Z Company for our round minigrafts (Figure D), and use the end of the index finger, which is held near the end of the punch, to help limit the depth of the hole produced.

The theoretical benefit of using these techniques should be that a hair surgeon can then be a little more aggressive in placing grafts closer together. In addition, at the time of the second or third transplant sessions, there should be less “micro-scarring” affecting the vascular support to the scalp, which should result in a higher percentage of hair growth. In the year and a half that we have been using this technique, these benefits do seem to occur. In patients with very thin scalp, this technique is a little more difficult to accomplish, but I believe even more important to attempt using. In such patients, slightly wider spacing of grafts should be used, and a steeper angle for the recipient site may allow the graft to fit in without penetrating vertically quite as deeply.

Biologic research recent progress

The adult mouse stem cells situated in the bulge of the hair follicle are able to regenerate the epithelium, hair follicle and sebaceous glands. These results obtained by a research team of INSERM have been published in the review CELL (Oshima & coll January 26 / 2001, vol 104). These researcher after localising stem cells were able to stain them. The stem cells grew into either keratinocytes, sebaceous gland cells, or hair follicle cells. They then followed the cells migration. Four weeks after the blue-stained cells where still found in the bulge. At 8 weeks some were seen in the external shaft of the follicle and some were found in the lowest portion of the follicle. AT 10 weeks began the formation of the hair. In a second stage the ability of the adult stem cells to generate either hair follicles, sebaceous glands, epidermis was studied. Some of these stem cells of an adult mouse were placed on the skin of a mouse embryo. Later on was observed the growth of epidermis, of sebaceous glands and hair follicle from these adult stem cells. By differentiating these stem cells it could become possible to either produce epidermis and correct burns or favor the scarring process as well as to produce hair follicles to correct baldness. The mechanism by which the stem cells chooses 1 of the 3 ways of differentiation is still unknown and to be search.
People…

ESHRS CONGRESS in Istanbul

Family photo for the happy few

Dr Piero Rosati

Dr O’Tar Norwood and friend, Dr Melike Kulahci, Dr David Seager, Mr Reiner Pfeiggen

Answering questions during the meeting: Dr Bessam Farjo, Dr Jerzy Kolasinski (Eshrs Vice-president), Dr David Seager and Dr Franck Neidel

Dr Jennifer Martinick, Mr Reiner, Dr and Mrs Mel Meyer and Dr Melike Kulahci

Dr Arturo Sandoval, Dr Melike Kulahci and Dr Ramon Vila-Rovira

Drs Bessam and Nilofer Farjo

Dr Nicholas Lusisic, Dr Carlos Velasco de Aliaga and Dr Alejandra Susacasa

Drs Loek Habbema and his wife

Dr Patrick Frechet, Dr Ciro de Sio, Dr Ramon Vila-Rovira and Dr Rom Shapiro

Dr Nikos Giannopoulos, Dr Melike Kulahci and Dr Panagiotis Vreuzanos

Dr Pekka Nyberg, Dr Patrick Frecher, Dr and Mrs Ramon Vila-Rovira, Dr Luigi Sala and Dr Massimo Marpero

Dr and Mrs Patrick Frecher, Dr and Mrs Walter Unger and Mrs Cinzia de Sio

A nice couple: Dr and Mrs Ciro de Sio

Dr and Mrs David Seager, Dr Melike Kulahci our Turkish host, Dr and Mrs Bradley Wolf

Dr and Mrs Bradley Wolf, Dr Melike Kulahci and Dr Ramon Vila-Rovira
Impressions from our friends…

I must tell you that I thoroughly enjoyed the ESHRS meeting in Paris two years ago. The educational program provided a unique European perspective that was refreshing for me to hear. I observed a more “laissez-faire” attitude toward patient care by the European speakers. This is NOT to say less quality of care, but a more relaxed manner in caring for their patients.

In the United States, where we live in such an aggressively litigious society, I think American surgeons are much less relaxed with their patients. We are so concerned about being brought into a lawsuit, that we sometimes “Walk on eggshells” around our patients.

Another wonderful aspect of the conference was the high quality of social events and camaraderie among the participants. Being at the prestigious and historic Hotel-Dieu, next to the beautiful Notre Dame Cathedral was truly awesome experience. And finally, the friendship and hospitality provided by the President and his lovely wife was greatly appreciated by all.

Impressions about Paris and Istanbul congress. Though now I am answering together these appreciations, they have been unique and totally different experiences for me. Paris, “Hôpital de l’Hôtel Dieu”, making us remember centuries in the history of medicine, of which this Congress was part of renewing knowledge about Hair Restoration Surgery. Our hosts, the Frechet couple, were outstanding, dear memories which I will always keep.

Istánbul, exotic city full of mistery, where the Congress had aswell a high scientific level and where we were kindly treated, all of these thanks to the great effort of Melike Kuelhacl. Dr. Carlos Velasco de Aliaga (Lima - Peru)

We are so concerned about being brought into a lawsuit, that we sometimes “Walk on eggshells” around our patients.

How do you handle this case?

FIRST CASE

A 23 year old boy with a history of Male Pattern Badness comes in consultation with initial signs of recession in the temple area.

Dr. Emiliano Lavezzari

(Lugano - Switzerland)

The biggest problem is represented by the expectations of a young man, whose dream is to regain his old tuft just after one only session. I stongly stress to this kind of patient that it is unavoidable that his recession will extend a part of the donor : hair is needed to replace the hair which is going to fall down later. At this stage the main goal is to maintain one’s image. For these patients I basically use micro in 0,75-1mm holes and suggest finasteride.

Dr. Ramon Vila Rovira

(Barcelona - Spain)

I propose this solution : to carry out 300-400 micrografts of 1 or 2 hair unit, trying to put the maximum number of implants per m² by means of small incisions.

Six month later, carry out a new session of 300-400 micrografts to complete the density and to obtain a really aesthetic and very satisfactory result.

Dr. Patrick Frechet

(Paris- France)

Because we have no scientific, nor clinic evidences of how bald a patient 23 years old may become later and also because psychologically the patient is often unable at this age to face his balding adult.

I will also inform him before treatment that he will need many more surgeries in the future which may include a total of 10000 hairs grafted plus 2 scalp extension and a 3 hair bearing transposition flap procedure.

SECOND CASE

A 35 year old man with a 5cm wide vertex male Pattern Badness comes in consultation for a surgical advice.

Dr. Emiliano Lavezzari

(Lugano - Switzerland)

As this patient shows or will show a fronto-temporal recession too, I carefully consider the donor area and patient's expectations. If he is interested in mainly solving the vertex baldness, I suggest him a graft session; otherwise I obtain good results employing slot punches (0,50x2,50mm) in one megasession.

Dr. Ramon Vila Rovira

(Barcelona - Spain)

I would advise him 1 or 2 standard reductions. A single reduction would probably be sufficient to reduce this 5cm. Otherwise, it would suffice to carry out a second reduction 6 month later.

Dr. Patrick Frechet

(Paris- France)

I shall start explaining this 35 years old patient, that his 5 cm wide vertex baldness, will probably become 15 cm wide by the age of 55-60 and that his frontal hairs may also be gone by then. I shall inform him that Finasteride may or not slow down or stop his hair loss and eventually allow his hairs to regrow moderately. If he wishes only the surgical option I shall tell him that he should have what I will call the 'Main surgical option' and then a patient comes in consultation for a surgical advice.

1) Consider that the medical treatment will work well and start by the graft option. I shall perform a graft session of 2500 hairs and see within the 2-5 years how the patient will react. I shall not be tempted to graft more hairs at the present time in case the medical treatment appears unsatisfactory. In such case I shall return to the “main option” i.e 2 scalp extension.

2) If he wants a permanent result until the age of 55-60 with the denser hair possible at the vertex I shall perform immediately the "main option".
Patient Expectations
By Dr. Robert Leonard
ISHRS Past President (Rhode Island - USA)

As surgical techniques improve virtually each year, hair restoration surgeons must always remember to carefully assess their patients’ expectations regarding their surgical results. No matter how wonderful and natural the results of your surgeries may be to you, if they do not meet the preconceived expectations by the patient, he will be disappointed. Educate them as to the progressive nature of male pattern hair loss, tell them, therefore, that hair restorative procedures will be multiple in nature. Let them know that we are attempting to create the illusion of more hair than will actually be transplanted. In short, do not promise more than can be realistically achieved.

Evaluation of expectations must be determined at the time of the initial consultation and should be again confirmed prior to surgery. If you feel that your patient does not have realistic expectations, you really should postpone the surgery until you are sure that he and you are in agreement.


discussions less bleeding, less vasovagal reactions and for the best convinced of the advantages of the two drugs and their use?

Some use only Valium I.M or and are afraid of Versed. Others, specially those working part or all the time with an anesthesiologist, commonly use Versed without any problem. What is the difference between the two drugs and their use?

Most hair transplant surgeons are convinced of the advantages of using anxiolytic drugs to decrease vasovagal reactions and for the best results less bleeding, less movement.

The main disadvantage is possible adverse effects not only during the operation but also postoperatively.

- Effect: all the anxiolytic and hypnotic drugs slow down and decrease breathing rate. Apea is even possible if there are problems of alcohol, snoring, increased sensitivity or overdose. Partial amnesia of the procedure can Occur.

- Dose: the effect for the same dose varies within a range from 1 to 10 from one person to another. I.M and P.O have the same very progressive absorption. I.V.: the action is practically instantaneous.

- Safety: it’s necessary to check efficient ventilation by speaking with the patient, by taking the pulse and even by monitoring with an oxymeter with the automatic alarm (legal concerns). If unexpected problems occur, it’s necessary to check practical things like a 3 multibladed knife. Doing so the wound closure is usually easy or very easy. When the wound is wided (usually more than 9 mm) tension while closing starts and as we know tension produces wide scars whatever the skill of the surgeon. Working with a 6mm wide wound gives me a good safety margin which may be very useful in some tight scams or some pathologic cases. Even a 6mm wide harvested area allows sessions of 3000 hairs. (I seldom wish more.) To harvest these 3000 hairs I harvest 13 cm2 from 2 strips 21,6 cm long. Because the scars obtained are very thin in most cases, I do not eliminate the previous scar during the following session and so on. I proceed this way for at least two other reasons:

1) if I removed my previous scar while harvesting the two 3mm strips, this would result in a wound 6mm wide plus the width of the previous scar which would increase tension when closing with the risk of a wider scar.

2) The quality of the hair bearing area close to the wound is never as perfect as in a non harvested area and would end up with less ideal grafts.

Conclusion
Versed I.V is most easily, managed than Valium, I.M or P.O. The action of Versed is most rapid, most intense, with a 3\text{\textfrac{1}{2}} hours duration shorter than Valium. It’s not necessary to wait a long time before repeating a small amount of the drugs as with Valium. The effect of Versed is best controlled with less ups and downs and continued effects than Valium, So when the patient leaves the surgery, the action of Versed is over. The only requirement is to look after or to monitor the patient in the operating room. If unexpected problem occurs, for practical and legal purposes, it’s better in the surgery than out, on the road or during the night. The Valium is best used on a patient during a one day hospitalisation, but Versed is ideal for ambulatory surgery as cosmetic surgery.

Disadvantage: Action of Valium is slower, longer than Versed and it’s necessary to wait a long time before repeating a small amount of drug because of the risk of an overdose majored by the wide range of the individual sensibility.

References:
- Davis Seager-forum/Nov 1999
- Robert Yoho-forum/Mars 2000
- Davis Seager-forum/May 2000
- Walter Unger-forum/July 2000

Valium versus Versed
By Dr. Philippe Parraud
(Rivesaltes - France)

Opinions about the use of Valium (diazepam) and Versed (midazolam) differ from one author to another. Some use only Valium I.M or and are afraid of Versed. Others, specially those working part or all the time with an anesthesiologist, commonly use Versed without any problem. What is the difference between the two drugs and their use?

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The Suturing technique:
I always harvest the strips superior to the nuchal ridge in order to have the galea present underneath. We have to keep in mind that an intact galea protects the wound from widening. Therefore I try my best not to cut the galea while cutting the strips and worse do not undermine it. When I use to do it several years ago my scars would always end up wider than expected.

Stitching: I use only a superficial suture. It is a 4-0 monofilament poliamide called ‘crimene’. The main steps while suturing are as follow:

A. I use a continuous suture.
B. The bites are 3mm away from the edge of the wound on each side.
C. The bites are 2-4mm a part on the same edge.
D. The edges of the wound are approximated by my assistant and not by placing tension on the suture. This way the suture closes the wound without ‘Cutting the tissues nor strangling the follicles.
E. The suture goes deep into the fatty layer of the scalp. It allows both edges of the wound to be in close contact on all the height of the wound wall allowing a good seal of all the wall of the future scar.

The key point in the suturing process is to reduce the tension of the suture so that the suture should be as closed as necessary to allow a ‘loose’ loop to avoid any tension on the suture and still offer a perfect approximation of both edges of the wound. Rarely the wound is difficult to close even though only 6mm wide tissues were taken of. Often some remaining fatty tissue is the cause. Once eliminated closure is usually easy. If exceptionally the wound is still a little hard to close I would make my loops even closer one another under no tension or else use a gap because this would produces scars rather than close under tension. These manoeuvres should be enough to obtain thin scars in most if not all cases. The suture is taken off 7 to 10 days later.

In the next issue of the newsletter I suggest that one of you takes the lead and tells us: ‘How does he deals with patients who bleeds much more than Usual’.

How do I close the Donor Area to obtain the thinnest scar possible
By Dr. Patrick Frechet
(Parns - France)

Width of the wound:
In my practice, I use Mini and Micrograft. And more precisely Microstrip grafts (0.66mm /3.00mm). Therefore I harvest 2 strips 3.00mm wide with a 3 multibladed knife. Doing so the wound closure is usually easy or very easy. When the wound is widened (usually more than 9 mm) tension while closing starts and as we know tension produces wide scars whatever the skill of the surgeon. Working with a 6mm wide wound gives me a good safety margin which may be very useful in some tight scams or some pathologic cases. Even a 6mm wide harvested area allows sessions of 3000 hairs. (I seldom wish more.) To harvest these 3000 hairs I harvest 13 cm2 from 2 strips 21,6 cm long. Because the scars obtained are very thin in most cases, I do not eliminate the previous scar during the following session and so on. I proceed this way for at least two other reasons:

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APPLICATION FORM FOR MEMBERSHIP

ESHRS
European Society of Hair Restoration Surgery.
46, avenue Foch 75116 Paris - France.
Tel.: 00 33 1 45 00 00 76 - Fax: 00 33 1 45 02 15 77

APPLICATION FORM FOR MEMBERSHIP

Name
Address
City                                   Postal Code
Phone                                   Fax
Medical Licence N°

Please enclose a photocopy of your Medical License to be registered

The yearly dues for Membership is: 200 Euro
An invoice to be paid will be sent to you after acceptance.

REGISTRATION FORM

PLEASE PRINT OR TYPE CLEARLY

Name                       Surname
Accompanying person’s name

Address
City
State
Zip Code
Country
Phone
Fax
E-mail

REGISTRATION FEES

Before mar 31st, 2001       After avril 1st, 2001

ESHRS Members    750 Euros       850 Euros
Non Members Physician 1050 Euros  1150 Euros
Residents Physician  360 Euros       420 Euros
Medical Assistants. Non Physicians  300 Euros   300 Euros
Accompanying person   300 Euros   300 Euros

TOTAL EUROS ___________ TOTAL EUROS ___________

LIVE SURGERY CATEGORIES

Before mar 31st, 2001       After avril 1st, 2001

ESHRS Members    250 Euros       350 Euros
Non Members Physician 350 Euros  450 Euros
Residents Physician 180 Euros  180 Euros
Medical Assistants. Non Physicians  120 Euros  120 Euros

TOTAL EUROS ___________ TOTAL EUROS ___________

DIDACTIC MORNING WORKSHOP SELECTIONS

Please indicate one of the four choices for each day by event number: Fee 100 Euro each

Thursday, 31st May
101       102       103       104
Friday, 1st June
201       202       203       204
Saturday, 2nd June
301       302       303       304
Sunday, 3rd June
401       402       403       404

TOTAL EUROS ___________

TOTAL AMOUNT TO BE PAID: ___________ EUROS

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If paying by check, make payable in Euro only to ESHRS and mail to: 46, avenue Foch 75116 Paris - France
Fax: 00 33 1 45 02 15 77

If paying by credit card, VISA only, complete the information below and mail or fax to:
ESHRS, 46, avenue Foch 75116 Paris - France
Fax: 00 33 1 45 02 15 77

VISA CARD NUMBER ___________________________ EXPIRATION DATE ___________

Authorized Signature:

Make sure not to miss
THE 4TH ANNUAL CONGRESS
of ESHRS in Barcelona
May 30 - June 3 2001

See how the previous ones were featured in Forum

2nd Congress of ESHRS in Paris.
“The International faculty was huge and the social program fantastic. With 128 registrants from 32 countries and 10 live surgeries, it is sure to be the second biggest meeting of the year. There were many excellent papers. A truly memorable few days.”
Dr. Russell Knudsen, Past President ISHRS (Sydney - Australia)

3rd Congress of ESHRS in Istanbul.
“Imagine a sapphire blue sea and a soft zephyr in the evenings, exquisite food shared with a hundred multicultural friends, wrap this in 2000 years of history, that was the ESHRS third conference held in Istanbul, a most memorable event.”
Dr. Jennifer Martinick, President of Australian Society of Hair Restoration Surgery. (Perth - Australia)

The next Congress is quickly approaching, if you have not yet registered, please make sure to do so. There are only limited places available for the live workshop.
Upcoming events

1ST TRAVELLING, WORKSHOP OF ISHRS AND WHS
April 28-29, 2001 Taegu - Korea
Program Director: Dr. Jung-Chul Kim
Fax: 0082 53 426-0770

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4th ANNUAL CONGRESS OF ESHRS
May 30 - June 3, 2001 Barcelona - Spain
Program Director
Dr. Ramon Vila-Rovira
Fax: 00 33 45 02 15 77

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9th ANNUAL CONGRESS OF ISHRS
October 18 -22, 2001 Puerto Vallarta
Program Director: Dr. Arturo Sandoval
Fax: 001 847 330-1135

Call for articles

All ESHRS Members are most welcome to send letters or articles to be published in ESHRS Journal.
The text should not exceed two pages.
Please send submissions preferably via a 3½ disk or E-mail
You can send your mail to:

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46, avenue Foch 75116 Paris - France

And your E-mail to:
dr.patrickfrechet@club-internet.fr