

Hair Repair: Donor Scar Repair

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History

A 53-year-old Caucasian was referred with a history of numerous surgeries starting 20 years ago that left him with wide, cosmetically unacceptable donor scars. A scar revision had been done seven months prior in an attempt to improve the appearance. No improvement was seen after scar revision. His main complaint is that he has to use upper parietal hair to cover up the scars on the posterior occipital donor area. On windy days, the scar is very noticeable. His physician retired and referred him to my clinic. This case was first presented in a previous issue of the *Forum* (Vol. 14, No. 4, July/August 2004, page 143).

Exam

The donor scar measures 24cm long by 4cm wide (Figure 1). There is only sparse hair growing within the scar.

There is almost no donor hair available from the traditional donor area. After close examination, I found there is still a little bit of donor hair available at both upper parietal areas.

The maximum donor from one side that I can remove is 8cm long by 0.4cm wide. Another side is 7.5cm long by 0.4cm wide. Total donor area available is 6.2cm². And the total scar area is 96cm² (24cm long by 4cm wide).



Figure 1.

Treatment

A previous scar revision had failed, and it was decided that more attempts to excise the scar would not be successful. If the whole scar area is grafted, the improvement will be minimal. This increase in density is not going to help much at all. Therefore, the scar area in each temple, measuring 5 cm long by 4 cm wide, was not treated. A decision was made to transplant only the occipital area and the transplanted area was reduced to 14cm long by 4cm wide (56cm²).

From 6.2cm² of excised donor area, 320 double follicular unit grafts were produced. The occipital scar was grafted at higher density at the top of the scar to give more hair to shingle downwards.

Follow Up

Seven months later, the patient returned for the follow up visit. He was completely satisfied with the posterior hair coverage (Figure 2). This case demonstrates that focusing a relatively small number of grafts into a cosmetically critical area can have a significant impact. ♦



Figure 2.

Live Surgery Workshop

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ing session, and Drs. Marco Barusco and Marcelo Gandelman combined their talents in performing an eyebrow transplant. In a research study comparing transection with a multi-blade knife versus free-hand incision, Dr. Vance Elliott used a 3-blade multi-blade knife holder and Dr. Glenn Charles excised with a #10 Personna blade. Identical 3cm lengths were examined and surprisingly there were 41 transected hairs in the multi-blade cut section and 70 transected hairs in the free-hand section.

Dr. Bill Parsley added, "I watched Jim Harris perform his FUE and checked his grafts. They were incredibly good. Checking them under the microscope, the grafts were intact

with less than 3-4% transection. There was a little kinking of the base of some of the follicles but it looked insignificant. I walked away feeling privileged to have been there to witness what I consider a breakthrough. Jim's too modest to brag on himself, so we will do it for him. His technique seems to be to rotate the sharp end 90° in only one direction, going no more than 1.3mm deep. Then switching to the dull end, he rotated it back and forth (counterclockwise, then clockwise) until it popped through to the subcutaneous layer. Removing the grafts consisted of simply plucking them out. Not only were the grafts good, but he was doing them fast."

With another full and intense day under their belts, faculty and attendees alike all headed for Pleasure Island for cocktails, snacks, and socializing. ♦