Year-over-Year Evolution in FUE Hair Transplant Case Mix, Session Size, Patient Travel Patterns, and Lead-to-Procedure Velocity Across a Bi-Regional U.S. Practice: A Retrospective 2024–2025 Internal Case Analysis

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Abstract

Background: Follicular Unit Extraction (FUE) hair transplantation has become a central technique in modern surgical hair restoration. The literature emphasizes that successful hair restoration requires careful patient selection, donor preservation, surgical planning, graft handling, and realistic long-term design. At the same time, contemporary patient demand increasingly reflects lifestyle considerations, discretion, travel willingness, and expectations for comprehensive single-session restoration.

Objective: To compare 2024 and 2025 AlviArmani U.S. FUE case patterns, with emphasis on graft-volume distribution, high-density session share, out-of-town patient travel patterns, and lead-to-procedure velocity.

Methods: A retrospective internal analysis was performed using AlviArmani U.S. case summaries from 2024 and 2025. Metrics reviewed included average grafts per case, median and mode graft counts, graft-band distribution, share of procedures exceeding 3,000 grafts, share of cases at or above 4,000 grafts, clinic-specific travel patterns, and interval from lead creation to scheduled procedure. Peer-reviewed literature was reviewed to contextualize the findings within broader FUE surgical principles and U.S. hair-transplant demand.

Results: The average graft count increased from approximately 2,210 grafts in 2024 to approximately 2,682.5 grafts in 2025. Median graft count rose from 2,500 to 3,000, while the mode increased from 3,000 to 3,500. The share of procedures exceeding 3,000 grafts increased from approximately 19.3% in 2024 to approximately 35.8% in 2025. Cases at or above 4,000 grafts increased from approximately 0.8% to approximately 1.7%. In 2025, the largest graft-volume band was $\geq$3,500 grafts, representing approximately 32.8% of cases. Lead-to-procedure velocity also improved, with median days from lead creation to procedure decreasing from approximately 52 days in 2024 to approximately 39 days in 2025, and average days decreasing from approximately 61 to 45.

Conclusion: Between 2024 and 2025, AlviArmani U.S. demonstrated a measurable shift toward larger single-session FUE procedures, increased high-density case share, and improved lead-to-procedure velocity. These findings suggest growing patient confidence in comprehensive one-session restoration, continued demand for destination-level surgical care, and operational maturation across a bi-regional practice model. The interpretation of larger case size should remain grounded in established hair-restoration principles: donor preservation, surgical planning, graft protection, patient selection, and long-term aesthetic design.

1. Introduction

Surgical hair restoration has evolved substantially over the past several decades, with follicular unit-based transplantation becoming the dominant framework for achieving natural-appearing results. FUE has become particularly important because it allows individual follicular units to be harvested without a linear donor scar; however, the technique remains highly dependent on surgical skill, donor management, instrumentation, graft handling, and appropriate patient selection.

Rose's review of hair restoration surgery emphasizes that important challenges in the field include finite donor hair availability, hair survival, and concealment of visible signs of surgery [1]. Sharma and Ranjan describe FUE as a technique requiring sound knowledge of surgical technique, armamentarium, and proper surgical planning, while also discussing risk, complications, holding solutions, and associated technical factors [2]. Beyond technique, patient demand for hair transplantation in the United States is shaped by the psychosocial burden of androgenetic alopecia, sex-specific expectations, willingness to pay, and interest in surgical intervention [3].

Within this broader clinical and patient-demand context, practice-level operational data can provide useful insight into how FUE case mix, graft-volume planning, patient travel patterns, and booking velocity evolve over time. AlviArmani's U.S. model includes Beverly Hills and Salt Lake City, representing a bi-regional structure with both national destination and regional access characteristics. The 2024 internal case page established a baseline year with a balanced graft-volume distribution, while the 2025 page showed a shift toward larger single-session procedures, higher median and modal graft counts, and faster lead-to-procedure timing [4, 5].

The purpose of this paper is to compare the 2024 and 2025 AlviArmani U.S. case summaries and interpret the findings in light of established FUE surgical principles and modern U.S. hair-transplant demand.

2. Methods

This study used a retrospective internal case analysis design. Data were drawn from AlviArmani U.S. procedural summaries for calendar years 2024 and 2025. The analysis included cases with numeric graft counts and confirmed scheduling data where available.

The following internal metrics were reviewed: average grafts per case, median and mode graft count, graft-volume distribution by band, share of procedures exceeding 3,000 grafts, share of

cases at or above 4,000 grafts, out-of-town patient share by clinic, and lead-to-procedure velocity measured as the interval between lead creation and scheduled procedure date.

Graft counts were grouped into five bands: fewer than 2,000 grafts; 2,000–2,499 grafts; 2,500–2,999 grafts; 3,000–3,499 grafts; and ≥3,500 grafts. High-density or "Maximus-level" procedures were defined in the AlviArmani source pages as procedures exceeding 3,000 grafts [4, 5]. Lead-to-procedure timing was measured using confirmed dated cases, with canceled procedures excluded in the 2025 methodology [5].

Peer-reviewed literature was used for clinical and market context only. It was not used to modify or infer AlviArmani internal case statistics.

3. Results

3.1. Overall Graft Volume

In 2024, the average graft count was approximately 2,210 grafts per case. The median graft count was 2,500, and the mode was 3,000. By 2025, the average graft count increased to approximately 2,682.5 grafts per case. The median increased to 3,000, and the mode increased to 3,500 [4, 5]. This represents a meaningful upward shift in case size. The rise in both median and mode suggests that the increase was not limited to a small number of unusually large cases, but instead reflected a broader movement in the center of the case distribution.

3.2. Graft-Band Distribution

The 2024 graft-volume distribution was comparatively balanced across mid-range and larger sessions, while the 2025 distribution shifted toward larger single-session restorations (Table 1; Figure 1).

Table 1: Graft-volume distribution by year.

Graft Band	2024 Share	2025 Share
<2,000 grafts	23.2%	17.4%
2,000–2,499 grafts	16.3%	11.7%
2,500–2,999 grafts	20.9%	16.4%
3,000–3,499 grafts	20.3%	21.7%
≥3,500 grafts	19.3%	32.8%

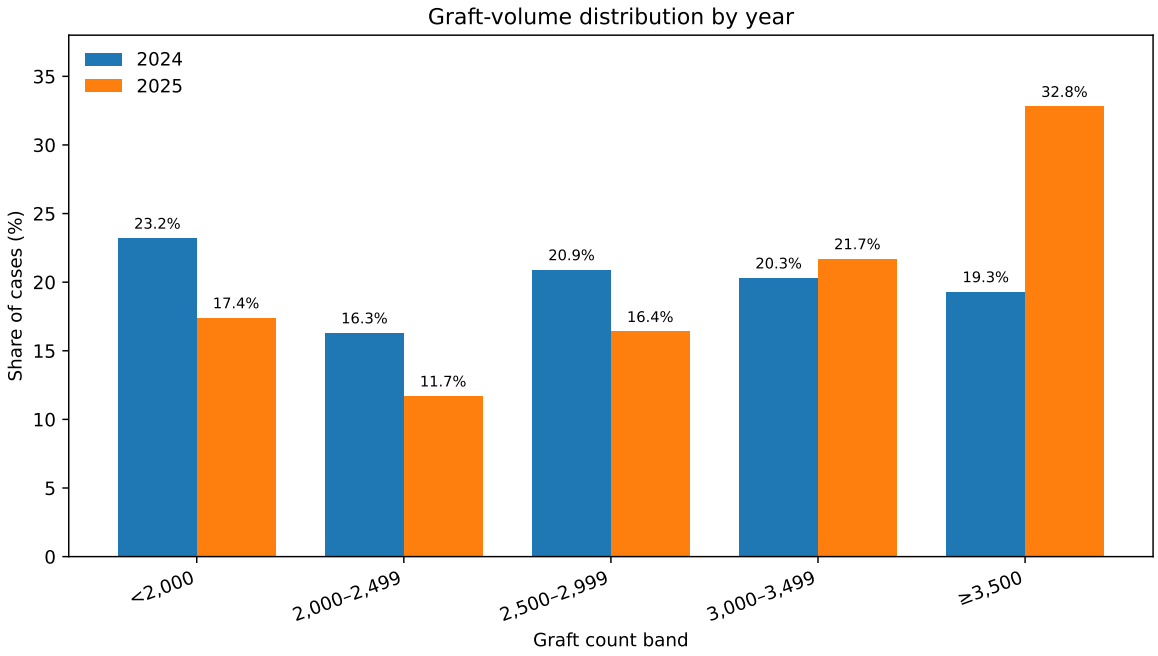

Figure 1: Graft-volume distribution by year. The most notable increase occurred in the ≥3,500-graft category, which rose from 19.3% in 2024 to 32.8% in 2025.

3.3. High-Density Session Share

The share of procedures exceeding 3,000 grafts increased from approximately 19.3% in 2024 to approximately 35.8% in 2025 (Figure 2). Cases at or above 4,000 grafts also increased, from approximately 0.8% in 2024 to approximately 1.7% in 2025. The highest observed case increased from 4,000 grafts in 2024 to 4,500 grafts in 2025 [4, 5].

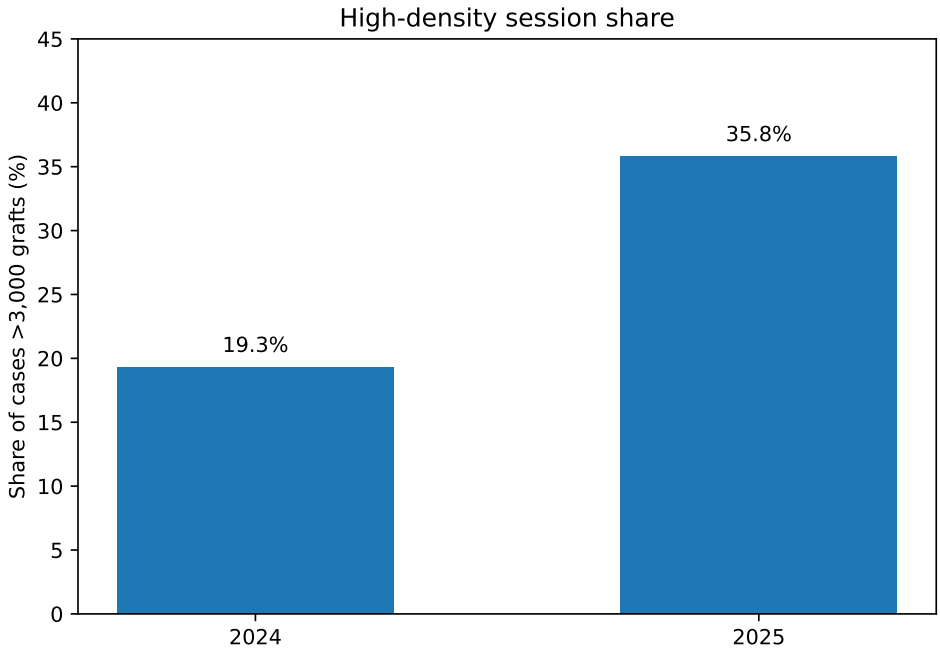

Figure 2: Share of cases exceeding 3,000 grafts by year.

3.4. Technique and Patient Experience Trends

The 2024 AlviArmani page describes a procedural landscape in which No-Shave FUE and Prive™ were emerging as meaningful patient-centered formats. The 2025 page emphasizes continued traction for advanced, patient-focused techniques aligned with lifestyle, privacy, and return-to-work expectations [4, 5].

Although the source data do not independently isolate technique-specific graft outcomes, the year-over-year shift toward larger graft sessions is consistent with increased patient interest in comprehensive one-session restoration. This interpretation should be understood in the context of the broader FUE literature, which emphasizes that larger or more complex FUE procedures require careful planning, donor management, and technical execution rather than simple graft-number escalation [1, 2].

3.5. Travel Patterns

In 2024, Beverly Hills had an out-of-town patient share of approximately 44%, while Salt Lake City had an out-of-state share of approximately 36%. Combined out-of-town share was reported at approximately 41% of all U.S. patients [4].

In 2025, the clinic-specific out-of-town share was reported as approximately 39.8% for Beverly Hills and approximately 26.0% for Salt Lake City. Beverly Hills continued to show a stronger destination profile, while Salt Lake City remained positioned as a regional hub with meaningful inbound demand from nearby Mountain West markets [5]. These clinic-specific patterns are shown

in Figure 3.

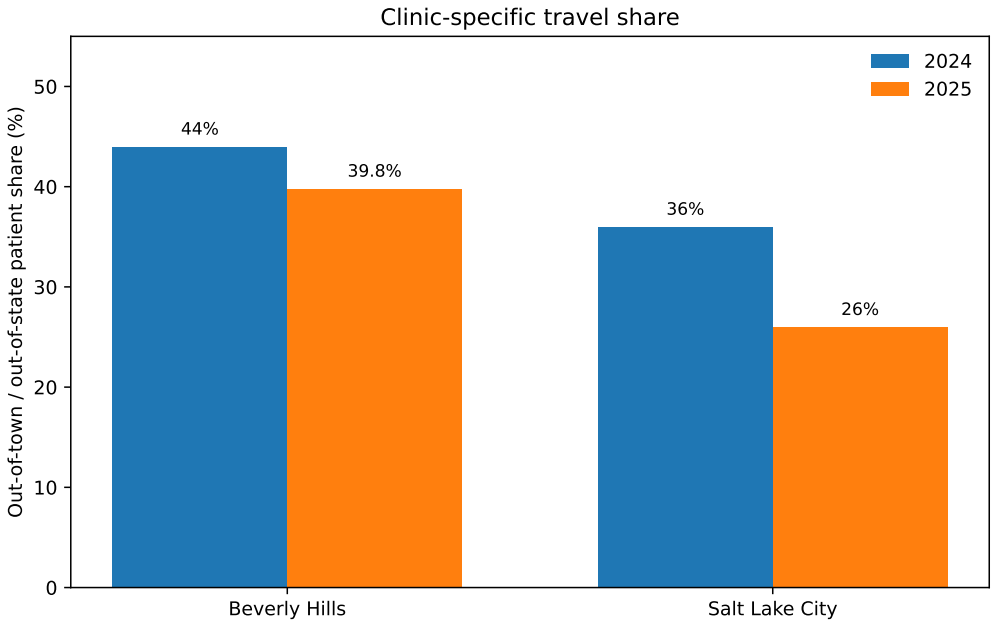

Figure 3: Clinic-specific out-of-town or out-of-state share by year. The 2024 source reports 44% for Beverly Hills, 36% for Salt Lake City, and approximately 41% combined; the 2025 source reports approximately 39.8% for Beverly Hills and 26.0% for Salt Lake City.

3.6. Lead-to-Procedure Velocity

Lead-to-procedure velocity improved substantially from 2024 to 2025. In 2024, the median interval from consultation or lead creation to procedure was approximately 52 days, with an average of approximately 61 days. In 2025, the median decreased to approximately 39 days, and the average decreased to approximately 45 days [4, 5]. This represents an approximate 25% improvement in median conversion speed (Figure 4).

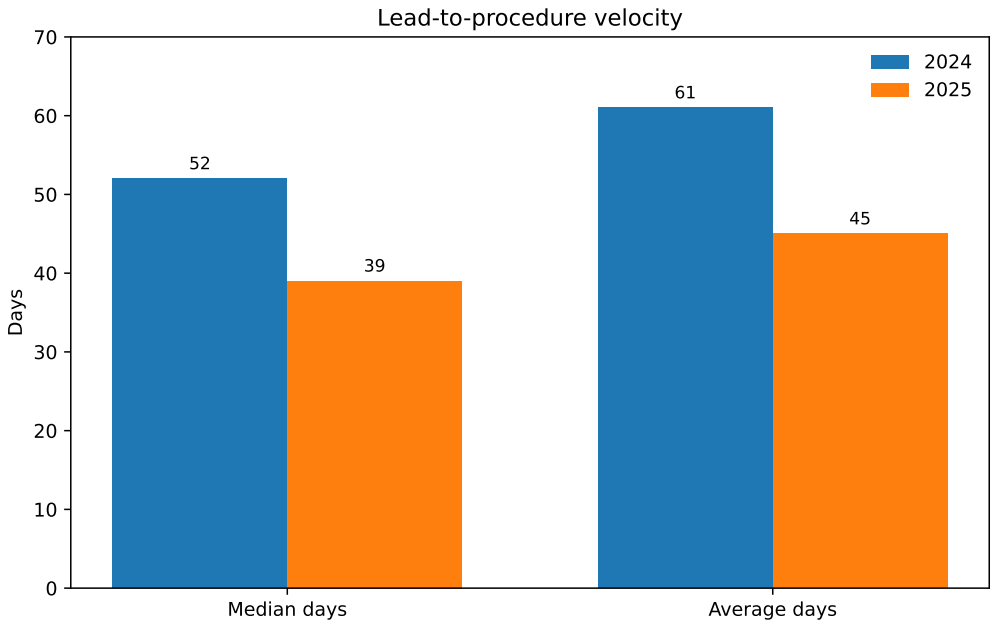

Figure 4: Lead-to-procedure velocity by year. Days were measured as the interval between lead creation and booked procedure date in the 2025 source methodology.

4. Discussion

The 2024–2025 comparison demonstrates three important themes: increasing case size, sustained destination demand, and improved operational velocity.

4.1. Larger FUE Sessions and Donor Stewardship

The shift toward larger single-session procedures is evident across multiple measures. Average graft count increased, the median rose from 2,500 to 3,000, and the mode increased from 3,000 to 3,500. The largest relative shift occurred in the $\geq$3,500-graft category, which became the dominant graft band in 2025.

From a clinical perspective, the increasing size of FUE sessions must be interpreted through the lens of donor-resource management. Rose emphasizes that long-term success in hair restoration depends on managing finite donor hair availability, hair survival, and the aesthetic need to minimize visible evidence of surgery [1]. Therefore, the key implication of the AlviArmani data is not simply that larger cases became more common. Rather, the data suggest a practice-level shift toward more comprehensive single-session planning within a framework that must remain anchored in donor preservation and long-term design.

4.2. Technical Complexity of FUE

FUE is often perceived by patients as minimally invasive because it avoids a linear donor scar. However, the literature makes clear that FUE remains technically demanding. Sharma and Ranjan

note that appropriate surgical planning, technique, instrumentation, and management of risks and complications are essential to achieving desired results [2]. This is particularly relevant when interpreting the rise in >3,000-graft and ≥3,500-graft cases. Larger FUE sessions may increase the importance of extraction pattern, donor-area distribution, graft hydration, graft survival, hairline design, recipient-site planning, and surgical-team coordination.

Figure 5 provides a conceptual workflow to contextualize how operational case metrics relate to clinical process.

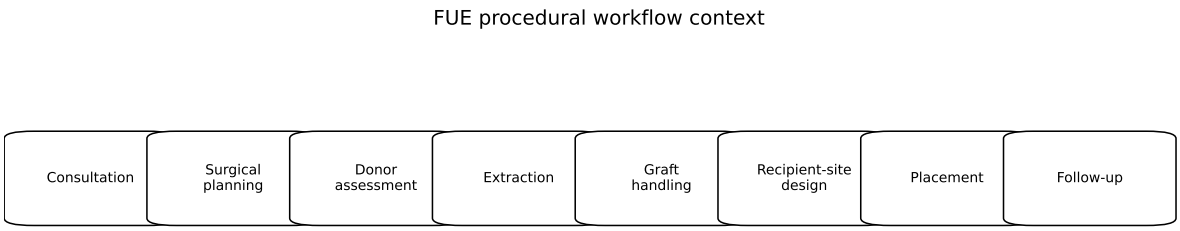

Figure 5: Conceptual FUE workflow context. The schematic is intended to show the relationship between consultation, donor assessment, extraction, graft handling, recipient-site design, placement, and follow-up.

4.3. Patient Demand and Willingness to Pursue Hair Transplantation

The U.S. population-based survey by Knoedler and colleagues supports the broader relevance of patient demand in hair transplantation. Their survey found sex-based differences in consideration of hair transplantation and willingness to pay, with fewer women considering hair transplantation than men but women who were willing to undergo hair transplantation reporting a higher willingness to pay [3]. This broader market context helps frame the AlviArmani travel and booking data. Patients appear willing to travel and commit to procedures when they perceive specialized expertise, aesthetic value, and procedural fit.

4.4. Operational Velocity as a Marker of Trust and Process Maturity

The improvement in median lead-to-procedure timing from approximately 52 days to 39 days may reflect several overlapping factors: stronger follow-up systems, clearer patient education, greater confidence in the procedure, limited surgical availability, and improved coordination between consultation and booking [4, 5]. In aesthetic surgical practices, booking velocity is not purely administrative. It may also reflect patient trust, clarity of recommendation, perceived urgency, and the patient's confidence that the proposed plan matches their goals.

4.5. Bi-Regional Model: Destination Prestige and Regional Access

The Beverly Hills and Salt Lake City split illustrates two complementary functions within the AlviArmani U.S. model. Beverly Hills appears to operate as the higher-destination-intensity clinic, supported by brand prestige and long-distance patient demand. Salt Lake City appears to strengthen access across the Mountain West, with a lower but still meaningful out-of-town share. This dual structure may allow the practice to preserve national brand value while expanding regional reach.

5. Limitations

This analysis has several limitations. First, it is based on internal case summaries rather than a prospectively designed clinical registry. Second, the data include operational metrics and graft-volume distributions but do not include independent clinical outcome scoring, blinded photographic assessment, graft survival analysis, complication rates, or standardized patient-reported outcome measures.

Third, travel classifications may be affected by missing state data, patient address documentation, or differences in how local versus out-of-town patients were categorized across years. Fourth, the available data do not isolate outcomes by technique, surgeon, Norwood class, donor density, hair caliber, prior transplant history, sex, age, or medication use. Fifth, although the literature provides important clinical context, the cited references do not validate the AlviArmani internal outcomes directly.

Despite these limitations, the year-over-year consistency of the internal metrics provides useful insight into practice evolution, patient demand, and operational performance.

6. Conclusion

Between 2024 and 2025, AlviArmani U.S. experienced a clear shift toward larger FUE hair transplant sessions, with higher average graft counts, a higher median and mode, and a substantially larger share of procedures exceeding 3,000 grafts. At the same time, the practice maintained a meaningful destination patient base across Beverly Hills and Salt Lake City and improved lead-to-procedure velocity.

The findings are consistent with broader trends in modern hair restoration: patients increasingly seek natural, comprehensive, and efficient solutions, while FUE technique requires disciplined surgical planning, donor preservation, and careful execution. Future analyses would be strengthened by integrating standardized photographic review, patient-reported satisfaction, donor-area assessment, complication tracking, and long-term follow-up.

Data Availability

The AlviArmani case metrics summarized in this manuscript are derived from internal website page drafts for the 2024 and 2025 AlviArmani U.S. case analyses. The peer-reviewed references are publicly available through PubMed Central.

Conflict of Interest Statement

The author is affiliated with AlviArmani. This manuscript describes internal AlviArmani practice metrics and should be interpreted as a retrospective internal case and operational analysis, not as an independently validated clinical outcomes trial.

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