www.ifssh.info VOLUME 8 | ISSUE 3 | NUMBER 31 | August 2018

ezine ifssh

CONNECTING OUR GLOBAL HAND SURGERY FAMILY

TIPS AND TECHNIQUES
PHALANGEAL NECK FRACTURES IN CHILDREN

HAND THERAPY:
HAND THERAPY IN ROMANIA

CONTROVERSIES

TRUTHFULNESS IN MEDICAL DATA REPORTING

CONTROVERSIES AND BEST PRACTICES FOR ACUTE SCAPHOID FRACTURE MANAGEMENT

THE CHANGING LANDSCAPE OF EVIDENCE-BASED MEDICINE

Watch your language!

The use of inappropriate language.

During my odd fifty years in medicine, I have listened to well over 10 000 presentations at various scientific meetings, seminars, congresses and academic conferences.

Over the years one has developed a filtering mechanism when listening to a presenter. In most cases the aim of the speaker (..and of course I include myself as a speaker!) is to convince the audience of a certain concept, idea, and nowadays, a new gadget or implant.

The words and phrases used to convince are often, and I mean often, inappropriate, meaningless and non-sensical. To use a "Trumpism": the language used is "fake".

We demand evidence based, accurate factual and proven results for written articles. Yet, when it comes to presentations, vague, ambiguous terminology and sentences are draped in eloquent language which, to the unsuspecting/un-sceptical listener sounds convincing and worth remembering. And to the newer members of our profession the convincing presentation may sound like gospel-truth, worthy of following.

This is especially true and sadly much more common in recent years when commercial interests are involved. The number of sponsored talks and workshops has escalated exponentially. And so has the "sales talk" become increasingly sophisticated.

My plea is: Do not confuse "opinion" with "fact".

Let me give just a few examples of "fake facts" dressed in "fake opinions", which I have collected over the years from keynote speakers at international congresses:

- "the majority of patients were happy",
- "we have observed satisfaction amongst most patients",
- "more than half would have the operation again",
- "our results were satisfactory",
- "on average this procedure is promising",
- "the results look promising",
- "we had no come-backs",
- "our data indicates a positive outcome",
- "the good and excellent results encouraged us",
- "we are impressed with this implant",
- "the preliminary results are promising"
- "our final results will be presented at the next meeting",
- "we are happy with our results so far",
- "no major complications were recorded".

This language is non-sense. It does not mean anything.

Stop wasting the Delegates' precious and expensive time with quasi talk and euphemisms.

Let's be civilised and honest in what we as colleagues proclaim to be true. Let's be more diligent when listening, but even more so when presenting.

With sincere regards,
Ulrich

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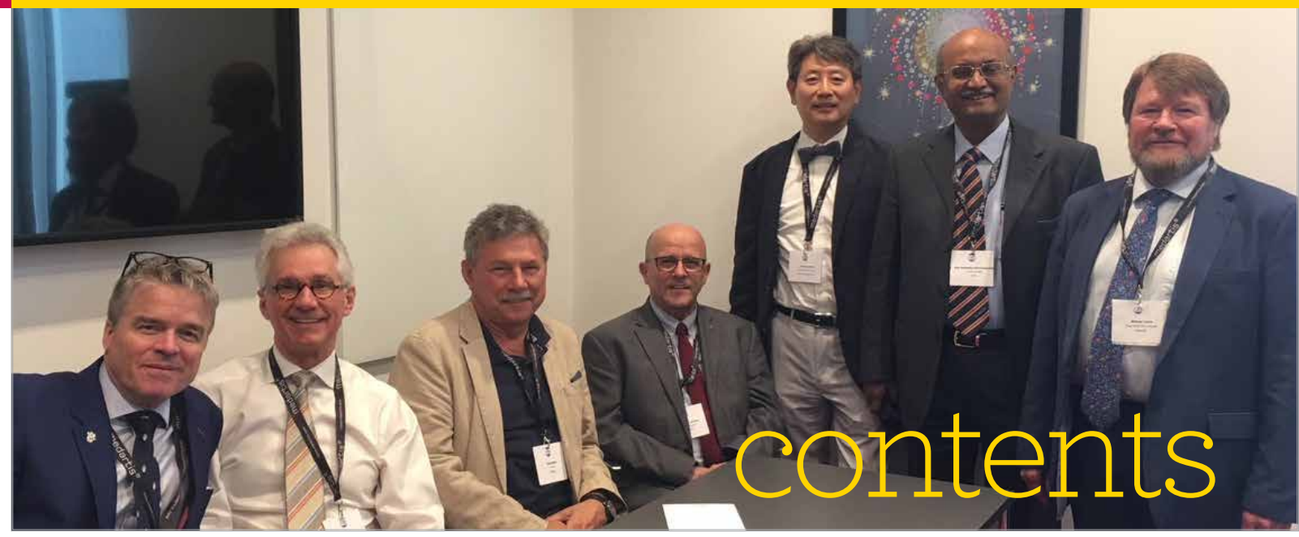

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Photo: Members of the IFSSH Exco June 2018, Copenhagen, Denmark

Truthfulness in *Medical Data Reporting*

When she entered my office, I didn't know that I would learn an important lesson that day. Like most of my patients, she had a long story to tell. She started experiencing pain in her right wrist on September 1989, when she was 19-years-old, and working as a hairdressing apprentice at her mother's hair salon. It took a number of tests for her doctors to put a name to that pain: idiopathic necrosis of the lunate, also known as lunato-malacia or Kienböck's disease (KD). She needed no tests to guess that her future as a hair stylist was at stake.

The weeks that followed could be described as a succession of treatment failures. Nothing appeared to work. By the end of June 1990, the avascular lunate was definitively fractured, and the joint was weaker and more painful than ever. Worried, she went to see a wrist specialist, a "young, long-haired doctor" who had spent time in the USA investigating wrist problems. Her first impression was encouraging: nobody had examined her wrist as meticulously as him. His final recommendation, however, surprised her. Instead of a list of conservative measures to control the disease, he gave her only one option: to surgically fuse the scaphoid to the distal row. At that stage, only a scapho-trapezio-trapezoidal (STT) arthrodesis could prevent her lunate from collapsing and becoming chronically painful, he concluded emphatically. Reluctant to accept surgery as the only means to alleviate her pain, she declined his help and left the room convinced that a "wait and see" strategy couldn't be as bad an alternative as that doctor's recommendation.
That turned out to be a smart move. As expected, the fragmented lunate collapsed. The scaphoid, however, did not sublux beyond the dorsal edge of the radius, as it usually does, but it laid down within the limits of the cartilage covered scaphoid fossa. That created a stable platform through which loads could be transferred. As a consequence, her pain started to subside, and slowly, but steadily, she recovered most of her hairdressing abilities. Needless to say, her wrist was stiffer than before, but functionally useful. "I wonder what would have happened had I followed that doctor's advice", she whispered dryly. Certainly, she was not aware that the "long-haired doctor" was me.

Was I honest when, 27 years ago, I proposed an STT fusion to that lady? I am not completely sure. According to most dictionaries, for a person to be completely honest, aside from well-intentioned, must also be truthful, that is, actively and continuously engaged in checking the correctness of one's beliefs, statements and/or actions. Was my recommendation correct? It all depends on what we considered correct back then. Let's not forget that we were in the early 90's and that Evidence-Based-Medicine still was in its infancy. At that time, the most frequently used treatment alternative for KD was a leveling procedure, most commonly a radial shortening osteotomy. In the adult, the technique gives clinically mixed results, the lunate collapsing most of the times, but the patient had less pain and better function than before surgery. Fusing the STT joint was another alternative. Assumed to unload the lunate more effectively than a leveling procedure,[1] the STT fusion was regarded by many as a novelty worth being tried. I was not an exception. When that young hairdresser entered my office, I saw the opportunity I was looking for.

Why didn't we critically appraise the poor evidence that existed at that time about the chances of success of that technique? Why so much emphasis in a procedure that had not been shown long term results yet? I am afraid that we did it because, in our naivety, we did not like unsolved "mysteries" in our treatment portfolios. Whatever the cost, we wanted to believe on the overwhelming collective enthusiasm about a technique that, in our simplified ways of understanding carpal mechanics, it just made sense. Fortunately she turned down my offer, and I didn't have to face the consequences of my overly enthusiastic judgment.

This story illustrates how much relying on a new technique with insufficient outcome information can potentially end up harming patients. Certainly, I didn't know it at the time, but in 2003 there was already enough evidence suggesting that fusing the STT joint did not guarantee lunate healing.[2] On the contrary, it alters carpal kinematics to a point where more than a third of patients develop painful dorso-radial impingement, a complication said to be prevented by resecting the dorsal rim of the radial styloid.

Needless saying, this wouldn't be a fair comment if it did not contain the following clarification. The case discussed above is not an attempt to point a finger at those who propose the STT fusion for a variety of conditions. That the lunate healing effect of the procedure could not be proven in my patients with KD does not mean that the fusion may not be of help in other circumstances. The lesson that I learned that day had to do with how easy it is for a young surgeon to be more influenced by the apparently successful results suggested in a big title, than by the real limitations of a procedure stated in the last paragraph.

But let's return to the initial question. Was I honest when I recommended a technique without complete information of their long term outcome? I guess I was not. Certainly, I do not intend to become a preacher of honesty nor accuse any colleague of the opposite. My only wish, when writing these lines, is to encourage the new generations of surgeons to be thorough in their assessment of reported findings and not to believe everything that has been published just because it looks good. When publishing, I urge them to have no hesitation to be completely truthful with their results, particularly about the limitations of their studies. Indeed, as an audience member, I am more likely to believe an honest publication/presentation with less overwhelming but truthful results, rather than a pristine paper with suspiciously perfect outcomes

1. Watson HK, Ryu J, DiBella A. An approach to Kienböck's disease: triscaphe arthrodesis. J Hand Surg Am. 1985;10: 179-87.
2. Minami A, Kato H, Suenaga N, Iwasaki N. Scapho-trapezio-trapezoid fusion: long-term follow-up study. J Orthop Sci. 2003;8(3):319-22.

(*) This essay includes ideas raised by different fellows of the Institut Kaplan during an informal case oriented discussion of the subject: "Truthfulness in medical data reporting". Particularly active in this regard were Dirck Añaños, FRACS, from Perth, Western Australia; Richard Jamieson FRACS (Orth), from Hobart, Tasmania; Dalia López Watson, MD, from Punta Arenas, Chile; Daniela Pérez, MD, from Santiago, Chile; Philip Mathew FRCS(Orth), form London, UK; and Amer Mustafa-Gondolbeu, MD, from Lleida, Spain

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ifsht
International Federation of Societies for Hand Therapy

To provide global networking and educational opportunities to develop and enhance the practice of hand therapy

UPDATE

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SPOTLIGHT ON IFSHT MEMBER SOCIETY: JAPAN

The Japan Hand Therapy Society (JHTS), established in 1988, holds annual meetings in collaboration with The Japanese Society for Surgery of the Hand. The 30th annual meeting, held in Tokyo in April 2018, had 670 therapists and surgeons attending. Dr. Moroe Beppu (St. Marianna University School of Medicine, APFSSH President 2012-2014) and Ms. Karen Shultz (CHT, University of Colorado) were keynote speakers. Dr. Mineo Oyama was elected President of JHTS, together with the new executive members. The next congress will be in Sapporo in April 2019. JHTS welcomes therapists from other countries to join the Congress.

The 30th annual meeting of JHTS in Tokyo. Nineteen executive members were elected, and Dr. Mineo Oyama was elected President (front row, 5th from left).

HAND REHABILITATION IN ZIMBABWE

Zimbabwe, a developing country, has experienced an economic crisis over the last decade. As a result, many clinics lack basic equipment for hand assessment and therapy. Dr. F.C. Muchemwa, a plastic surgeon, conducted a refresher workshop at the department of Rehabilitation, University of Zimbabwe onJanuary 16-19, 2018 for students, physiotherapists and occupational therapists. The workshop, facilitated by Magan Blakeway and Anne McGregor from St George's Hospital, University of London covered assessments of hand injuries, burns, nerve injuries, congenital deformities and splinting, among other topics. IFSHT donated a dynamometer to the College of Health Sciences, The University of Zimbabwe.

Prof. Masanganise, Dean, College of Health Sciences, The University of Zimbabwe receives a dynamometer from IFSHT, together with Ms. Chikwanha, chairperson, Department of Rehabilitation.

FESSH, COPENHAGEN 2019

Anne Wajon, IFSHT President, presented an IFSHT activity update to the IFSSH Council during the FESSH conference. Amongst other updates, she discussed the provision of IFSHT travel grants to support therapists teaching in Nepal and Rwanda.

BERLIN SITE VISIT, JUNE 2018

Members of InterCongress (IC), IFSSH, FESSH, and the German Hand Surgery (DGH) and Therapy (DAHTH) societies were joined by Anne Wajon for a tour of City Cube, the venue of the IFSHT/IFSSH Congress. Detailed plans for the scientific and social program were discussed. With less than one year until the Congress begins, registration and abstract submission is now open at: **http://ifssh-ifsht2019.com.**

L to R: Anne Wajon (IFSHT), Melinda Szabo, Dan Nagle (IFSSH), Zsolt Szabo (IFSSH), Jorg van Schoonhoven (DGH), Denise Schuler (IC), Isabell Faad (IC), and Max Hearle,(DGH/FESSH). Not pictured: Beate Jung and Daniela Neye (DAHTH).

IFSSH EZINE

The IFSHT contribution to the April 2018 EZINE is "Low-Profile Dynamic PIP Joint Orthosis" by Joy Hanna, a physiotherapist from Brisbane, Australia. The paper focuses on a low-profile dynamic PIP joint orthosis and its application. Please submit an article for the ezine to: **informationofficer@IFSHT.org**.

For hand therapy educational events, go to "National/International Education Events" under "Education" at **www.IFSHT.org**.

11th Triennial IFSHT Congress | Berlin, Germany | June 17-21, 2019 | ifssh-ifsht2019.com

Message

Delegates and societies are reminded that Pioneer nominations for outstanding and exceptional contribution to hand surgery must be received by the administrative office by 17 December 2018.

Nominations must follow the format detailed in the May 2018 IFSSH Ezine and previous IFSSH newsletter and be accompanied by the appropriate documentation, which is listed on the website, along with the checklist document confirming that all criteria have been completed.

Nominations for President-Elect, Secretary General-Elect, Historian and Member-at-large will be considered at the Berlin IFSSH Congress Delegates' Council meeting. These nominations must be received from a member society, signed by the society President and the society IFSSH delegate, or from members of the IFSSH Executive Committee, and may be received up to and including the time of the Delegates' Council meeting (according to current By-laws).

However, we recommend that nominations be forwarded to the IFSSH administrative office by 17 December 2018. It is intended that delegates consider an amendment to the By-laws at the Berlin meeting to establish this more formal process of nomination to the Executive Committee.

MICHAEL TONKIN
CHAIR, IFSSH NOMINATING COMMITTEE
IMMEDIATE PAST PRESIDENT

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SECRETARY-GENERAL REPORT

Secretary-General Report

The IFSSH Executive Committee (ExCo) and Delegates' Council met in Copenhagen during the June 2018 XXII FESSH Congress. The ExCo and IFSSH Delegates are indeed grateful for the hospitality extended to the IFSSH ExCo and Delegates by the FESSH leadership Dr. Michel Boeckstyns (Congress President) and Dr. Maurizio Calcagni (FESSH Secretary-General).

The ExCo meeting was held on Wednesday 13 June 2018. All ExCo members were in attendance. The Delegates' Council Meeting was held the following day and was attended by 29 Delegates along with delegates from the Asian Pacific Federation of Societies for Surgery of the Hand (APFSSH), the FESSH, the South American Federation of Societies for Surgery of the Hand, Hand and Wrist Biomechanics International, and the congress chairs of the upcoming 2019 Berlin (Dr. Jörg van Schoonhoven) and 2022 London (Dr. David Shewring) IFSSH Congresses.

Dr. Zsolt Szabo, IFSSH President, addressed the Delegates and stated that the dissemination of hand surgery knowledge, particularly to those areas of the world which are underserved by hand surgeons, is one of the IFSSH's most important activities. He pointed out that the IFSSH stands ready to support regional and local hand surgery congresses and fellowships. He reminded the Delegates that the IFSSH has created the Harold Kleinert Visiting Professorship which is designed to provide up to $20,000 to support the visit of a qualified senior hand surgeon to a hand surgery centre. (Please go to the IFSSH website for more information on the Harold Kleinert Visiting Professorship http://ifssh.info/fellowship-grants.html and http://www.ifssh.info/Educational_Sponsorship_Guidelines.pdf for information regarding the IFSSH sponsorship guidelines.) Dr. Szabo stressed that the success of the IFSSH outreach endeavours rests squarely on the shoulders of the IFSSH member societies. The Committee for Educational Sponsorship (CES) stands ready to support hand surgery education but the IFSSH member societies are the primary originators of such educational events.

The Committee for Educational Sponsorship (Dr. Marc Garcia-Elias (chair), Dr. Goo Hyun Baek and Dr. Raja Sabapathy with input from Dr. David Warwick) has funded two applications for support since the Delegates' Council last met in San Francisco. Dr. Zuidam of the Department of Plastic, Reconstructive and Hand Surgery of the Erasmus Medical Centre in Rotterdam, Netherlands, was awarded a grant of $10,000 in support of the Esser Masterclass series. The Esser Masterclasses are anatomy-based hands- on-courses that provide education in the field of hand surgery and are endorsed by the Netherlands Society for Surgery of the Hand. In keeping with the general philosophy of the IFSSH to support those in need, the ExCo provided this grant with the stipulation that the money be used to reduce the registration fee for those physicians in need of financial assistance. The grant was also to be used to support the online education platform that will allow the Esser Masterclass resources to be shared with those who cannot physically attend the courses. A second grant was provided to Dr Mohamed Abdelrahman, a plastic surgeon from Sudan, to enable him to undertake further hand surgery training in Shandong, China. Dr. Abdelrahman's grant request was supported by the Association of Chinese-Speaking Hand Surgeons United and was very carefully reviewed. It was felt that furthering Dr. Abdelrahman's hand surgery education had the potential to significantly impact the quality of hand surgery in Sudan. As per the IFSSH Protocols, each recipient of a grant will provide the IFSSH with a written report of their experience which will be shared with the IFSSH member societies through the IFSSH Ezine and Newsletter.

Dr. Goo Hyun Baek, the Secretary General Elect and Dr. Raja Sabapathy, the Member-at-Large, presented recommendations to clarify and simplify the grant application process. Their recommendations were reviewed by the ExCo and will be communicated to the Delegates in an upcoming Newsletter.

The ability to support educational grants of course, is dependent on the financial health of the IFSSH. Dr. Daniel Nagle the IFSSH Secretary General, updated the Delegates on the IFSSH finances and was happy to report that the organization is financially healthy and is well positioned to continue to provide educational grants. The funds of the IFSSH are conservatively invested and continue to grow and generate revenue used to help fund the IFSSH philanthropic endeavours.

Dr. Steven Hovius, the Chair of the Hand and Wrist section of the International Consortium for Health Outcomes Measurement (ICHOM), provided an overview of the ICHOM project. The Hand and Wrist project will look at the existing hand surgery outcome measurement tools and design a core set of measurements that would be applicable for the most frequently performed hand surgery procedures. Dr. Hovius asked for IFSSH endorsement and financial support for the project. The IFSSH delegates agreed the ICHOM would be of benefit to world hand surgery and voted unanimously to endorse the project and provide it with a $10,000 grant.

The IFSSH Historian, Dr. David Warwick, has been leading the charge to bring the IFSSH communications capabilities into the 21st century. He, along with Dr. Sabapathy and our Webmaster Santhosh Kumar, has been diligently updating the IFSSH website which will go live in the near future. In addition to the website update Dr. Warwick has been investigating how the IFSSH might benefit from the use of "social media." Thanks to Dr. Warwick the IFSSH now has a Twitter account. Dr. Warwick has been busy uploading Tweets of the recent Copenhagen meeting and I encourage you to follow the IFSSH at: @IFSSHand.

We are now moving toward the 14thTriennial IFSSH congress that will be held in Berlin 17 -21 June 2019. The hosting German Society for Surgery of the Hand (DGH) and the German Society for Hand Therapy (DAHTH) during a recent site visit, provided a thorough tour of the congress venue and overview of the meeting educational and social activities to Dr. Szabo and Dr. Nagle as well as to Anne Wajon (President of the IFSHT). Dr. Jörg van Schoonhoven and Dr. Max Haerle, members of the local organizing committee, were most gracious hosts during the Berlin site visit. The new Berlin CUBE Congress Center will serve our needs well and the city of Berlin offers a dazzling array of cultural and gastronomic options. The local hosts have made a commitment to provide excellent educational content at an affordable price. I hope to see you at the Berlin CUBE June 17 -21, 2019!

FUTURE MEETINGS

Triennial IFSSH Congresses
XIVth IFSSH – XIth IFSHT Congress – Berlin, Germany 17-21 June, 2019. www.ifssh-ifsht2019.com
XVth IFSSH – XIIth IFSHT Congress – London, United Kingdom. 2022 (Dates to be confirmed)

National and Regional hand surgery meetings
Please see announcements in the IFSSH Ezine and IFSSH website.

Best wishes to all from the IFSSH Executive Committee.

DANIEL J. NAGLE MD
SECRETARY GENERAL IFSSH

IFSSH & IFSHT

TRIENNIAL CONGRESS AND FESSH CONGRESS 2019

17th to 21st June in Berlin, Germany

Abstract submission is open (deadline 30 September 2018)

In June - directly after the successful FESSH Congress in Copenhagen and exactly one year before the Triennial IFSSH & IFSHT Congress 2019 - the organizing committee met the IFSSH President Zsolt Szabo and the Secretary General Daniel Nagle as well as the IFSHT President Anne Wajon in Berlin to present the city and the event location of the upcoming congress. Berlin presented itself with the most beautiful sunny weather and the multifunctional congress venue CityCube impressed the participants with its professional and flexible infrastructure which offers a lot of possibilities for the congress and the exhibition.

The abstract submission platform is open since 1st March 2018. According to the congress mission "Building bridges – Together Hand in Hand" it is our aim to bring together all the various disciplines of hand surgery and therapy from all parts of the world. Please feel kindly invited to actively participate in the scientific program and submit your abstract until 30 September 2018.

To stay up-to-date and to receive all important information please click here http://ifssh-ifsht2019.com/newsletter/ and register for the newsletter. Due to data protection regulations we need your permission to inform you about the Congress. The organizing committee is looking forward to meeting you in Berlin!

JÖRG VAN SCHOONHOVEN & MAX HAERLE & ANDREAS EISENSCHENK & NATASCHA WEIHS

Miguel Vargas Busquets

MD (1936-1993), Puerto Rico

Miguel Vargas Busquets, better known as Mickey, was born in Mayaguez, Puerto Rico in 1936. He completed his college education at the Mayaguez Campus of the University of Puerto Rico and his medical studies at the Medical School of the University of Zaragoza in Spain, graduating in 1964.

While in medical school he demonstrated his deep commitment to science and medicine and his outstanding organizing ability. As a student, he published works on microbiology and organized the Association of Hispanic Students in Zaragoza which helped to cement excellent relationships between the Latin-American students and the city. During his stay in Zaragoza he was invested as a Knight of Our Lady de Pilar, the Patron Saint of Zaragoza and Spain, a highly prestigious national organization. Dr. Vargas trained in surgery at the District Hospital of the University of Puerto Rico School of Medicine in 1967 and finished his surgical training at the Dallas Veterans Administration Hospital (1968-1970). He took his training in plastic surgery at the Parkland and Affiliated Hospitals of the University of Texas Southwestern Medical School (1971-1972) and became Diplomate of the American Board of Plastic Surgery in 1974.

After his training, Mickey returned to Mayaguez and became very active in the medical community especially in the practice of hand and plastic surgery. He founded the first clinic for ambulatory surgery in Puerto Rico in 1981 and named it "Instituto de Cirugia Plastica del Oeste, Inc" (ICPO). He was Founder Member and Past-President of the Puerto Rico Society for Surgery of the Hand. He was the driving force behind the acceptance of the Puerto Rico Society for Surgery of the Hand as a member of the International Federation of Societies for Surgery of the Hand. He was Founder Member of the Puerto Rico Society for Plastic Surgery and its President for four terms of office. He was a member of the American Association for Hand Surgery and the American Society for Surgery of the Hand. He was Corresponding Member of the Argentinian Hand Society. He was very active in teaching hand surgery in Puerto Rico and travelled the whole world spreading the gospel of excellence in surgery of the hand.

One of his greatest satisfactions was his tenure as Secretary General of the IFSSH, to which he dedicated an incredible amount of time from 1989 until the time of his sudden death on 17 November, 1993. His untiring efforts and correspondence with all its members helped to bring the Federation closer together. The American Society for Surgery of the Hand named one of its library rooms in his honour.
His wife, Tati, was always at Mickey's side, giving him encouragement and support. They have three sons, Miguel, Oscar and Alberto.

Miguel Vargas Busquets was honoured as "Pioneer of Hand Surgery" in Vancouver, B.C., Canada, in 1998, at the Seventh Congress of the International Federation of Societies for Surgery of the Hand.

Robert Malcolm McFarlane

MD, MSc, FRCSC (1927 – 2006), Canada

Bob McFarlane was born in London, Ontario, Canada on May 28, 1927. He graduated in medicine from the University of Western Ontario (UWO) in 1951. He gained certification in general surgery before taking further training in plastic and hand surgery in London and Leeds, England, with Rainsford Mowlem and Mortimer Shaw, and in Chicago with Sumner L. Koch, Michael L. Mason, John Bell and William Stromberg.

After his return to Canada in 1960, he established a residency program in plastic surgery at UWO and remained Head of the Division of Plastic Surgery until his retirement in 1992, as Emeritus Professor of Surgery. At that time he joined Jim Roth to establish The Hand and Upper Limb Centre at St. Joseph's Health Centre in London.

His early research concerned the delay phenomenon in pedicle skin flaps and other methods of preventing flap necrosis. He developed a flap in the rat that became the standard experimental model in which to study necrosis. Since his residency he has had a consuming interest in Dupuytren's disease. He extended the anatomical studies of previous surgeons such as Kaplan, Gosset, Littler, Stack, and Thomine by identifying the specific fascial structures responsible for joint contracture. Within the Dupuytren's Disease Committee of the International Federation of Societies for Surgery of the Hand (IFSSH), he conducted an epidemiological study of surgical patients that began in 1980 and collected data on 11500 patients, provided by 108 surgeons from 12 countries. The information obtained from that study was too extensive to be published in a journal but was included as a chapter in the book, Dupuytren's Disease by McFarlane, McGrouther, and Flint that was published in 1990.

His other interest included the etiology and treatment of camptodactyly. Prof. McFarlane was the author of 52 scientific papers, 42 book chapters, and two books. He has been an associate editor of the Plastic and Reconstructive Surgery Journal, and both of the American and British Journals of Hand Surgery. He is a Past-President of The Canadian Society of Plastic Surgeons and The American Society for Surgery of the Hand, and an honorary member of several National Hand Surgery Societies.

As Delegate, Secretary-General, and President of the IFSSH, he has travelled to many countries as an ambassador of the Federation to encourage the development of hand surgery and hand therapy, as well as the formation of Hand Societies to join the IFSSH.

He married his wife Patricia in 1951 and they had three daughters. During his student years he was regarded as one of the most outstanding athletes in Canada. He was included in the Canadian Olympic team in 1948 (London, UK) and had the honour to be the team flag bearer. He participated in numerous other sport activities throughout his life. His other non-medical interests included breeding of horses, and of course created the inevitable model train setup for his grandchildren.

Bob McFarlane passed away on 27 February 2006. For his immense contribution to Hand Surgery internationally, Robert M McFarlane was honoured "Pioneer of Hand Surgery" in 1998 at the Seventh Congress of the IFSSH in Vancouver, B.C., Canada.

The Changing Landscape of *Evidence-Based Medicine*

LEONARD C. MARAIS PHD

It is difficult to find fault with the reasoning behind the move towards an evidence-based approach in the teaching and practice of clinical medicine. With numerous therapeutic options available, treatment strategy selection has to be based on more than just intuition and prior experience. Furthermore, there are several strong arguments for the need to practice Evidence-Based Medicine (EBM). We have seen novel implant technologies entering the market, only to exit relatively shortly afterwards. Recall metal-on-metal hip articulations being hailed as the solution to all our problems? Less than five years later we saw reports of 49% failure rates at six-year follow-up.[1] In addition, research continues to disprove long-standing orthopaedic axioms. We can, with relative confidence, now say that debriding an open fracture within six hours is not as important as previously believed.[2] This principle is also illustrated by a recent randomized study that found no advantage in the damage control concept in the treatment of femur shaft fractures in poly-trauma patients.[3] Interestingly, patients treated with external fixation in this series had an increased time in ICU on ventilation compared to patients treated by reamed nailing of the femur. And thus, the evidence-based tenet remains largely intact.

It is, however, becoming increasing difficult to practice and teach evidence-based medicine in the field of musculoskeletal medicine. The first obstacle we face is the sheer quantity of data. For example, a cursory Google Scholar search for articles related to carpal tunnel syndrome revealed about 137 000 items. Even scanning through the titles would take an inordinate amount of time. Staying abreast of the available evidence is made even more difficult by the number of journals that we have to follow. It is no longer sufficient to follow the two or three "major" discipline specific journals. Articles of significance are now found in a wide range of publications, necessitating an alternative approach. The second, and perhaps the more pertinent, challenge we face relates to the quality of data and the interpretation thereof. In his landmark article, Ioannidis (by means of a rather complex argument) proposes that most published research findings may be false.[4] The author argues that research findings from underpowered, early-phase clinical trials would be true about one in four times, or even less frequently if bias is present. Ioannidis goes one step further stating that claimed research findings may often be simply accurate measures of the prevailing bias. Thus, most medical research operates in areas with very low probability for true findings and large or highly significant effects may actually more likely be signs of large bias.

Furthermore, a culture of reliance of p-values has emerged. There are however numerous problems with the use of p-values. P-hacking, also known as selective reporting or inflation bias, typically involves the misreporting of true effect sizes.[5] It occurs, for example, when researchers selectively employ certain statistical methodologies and/or data eligibility criteria in order to obtain a significant result. Aschwanden has eloquently illustrated, with the aid of an interactive infographic, how simple it can be to manipulate a p-value by simply changing a variable.[6] "Data dredging" and the shotgun approach to data analysis involves bombarding data with statistical tests until something significant is found. The problem is that as clinicians we are not necessarily adequately equipped with either the skill or the time to detect all the subtle errors, biases or statistical manipulations present in the evidence base. A recent personal experience, while reviewing a "big data" paper for an international publication, attests to this. On the face of it all appeared well with the manuscript. Something peculiar, however, prompted me to discuss the findings with an experienced statistician. After careful scrutiny several serious scientific flaws (albeit accidental) came to light, which essentially invalidated the findings. None the less, the article was subsequently published in a different international medical journal. Another problem with the quality of "the evidence" has to do with the interpretation of the data analysis. Abdullah and co-workers found that 28% of orthopaedic randomized controlled trials with negative findings were underpowered.[5] This means that a large proportion of studies reporting "no significant difference" is in fact not adequately powered to detect a clinically meaningful difference between groups, which then leads to inappropriately failing to reject the null hypothesis. These factors have led to many questioning the value of EBM in its current guise.

> "Performing high-quality research that is based on excellent protocols that employ standardized international outcome measures will allow subsequent incorporation into meta-analysis, which in turn strengthens our evidence base."

In 2014 Gary Klein argued for the retirement of the idea of EBM based in the fact that the science behind science is neither infallible nor comprehensive.[7] The author points out that too many medical studies cannot be replicated and that many studies with negative findings never get published. This so-called publication bias is illustrated by the fact that only 17% of surgical papers published between 2000 and 2006 reported negative findings.[8] Furthermore, Stahel and Mauffrey argues that EBM may not only be stifling innovation in orthopaedic surgery, it may also compromise patient safety.[9] Notably, there is a lack of evidence supporting the EBM approach. Perhaps Every-Palmer and Howick stated it best: "Given that EBM firmly favours an empirical approach over expert opinion and mechanistic rationale, it is ironic that its widespread acceptance has been based on expert opinion and mechanistic reasoning, rather than EBM 'evidence' that it actually works".[10]

But, if evidenced-based medicine is somewhat flawed: Where to go to from here? The problem does not necessarily lie with the EBM premise but "the evidence" or data, and the access to it. In fact, thoughtful meta-analysis is an extremely useful tool to address many of the preceding problems. We simply cannot return to the days of unverified anecdotes. In terms of the quality of data, novel methodologies have emerged that also rekindle the value offered by experienced and knowledgeable experts. Expert consensus-based medicine (ECBM) is a new concept that appears to be sensible alternative to guide our practice in areas where evidence is limited.[8] A recent example of this strategy is the 'International Consensus Meeting on Surgical Site and Periprosthetic Joint

Infection'.[11] This guideline was developed using the Delphi methodology, which seems to be growing in popularity.[12]

> "....too many medical studies cannot be replicated and that many studies with negative findings never get published"

Instead of retiring EBM in its entirety we could rather focus our attention on improving the quality of our evidence. Traditionally, the ideal trial is described as having high internal validity while maintaining high external validity.[13] This balance is unfortunately difficult to achieve and high internal validity often comes at the expense of external validity.[14] Internal validity reflects the elimination of bias from a study, ensuring that the findings are representative of the true association between exposure and outcome. Internal validity can be increased for example by performing larger, registered (and therefore scrutinized) studies with standardized outcome measures and extremely low risk of bias. External validity refers to the degree to which research findings can be applied to other groups or populations. Clinical scenarios are complex, involving a wide range of variables, while scientific research tends to be simplified. Take the following hypothesis: Does total shoulder arthroplasty result in a decreased rate of unplanned reoperation when compare to hemi-arthroplasty in patients over the age of 50 years. While the research question needs to be pragmatic in order to allow the necessary scientific rigor, and thus maximize internal validity, it can rarely mimic every clinical scenario. Therefore external validity may be increased, for example, by minimizing inclusion criteria (a strategy popular in some of the current large research projects).

Increasing the power of a study can also enhance internal validity. While increasing the sample size remains a valuable strategy, large studies have numerous problems. Caution should be applied when interpreting large studies, as they are more likely to find a formally statistical significant difference for a trivial effect that is not really meaningfully different from the null.[4] Ioannidis, therefore, suggests that large studies should ideally target major concepts (rather than specific questions) with a considerably high pre-test probability of being true so that a significant research finding will lead to a post-test probability that would be considered quite definitive. Another strategy to improve external validity would be to keep the source populations closely related to the target population. In other words the population studies should accurately reflect the population in whom the study findings are to be implemented. This may imply smaller more focused studies.

Logistical and financial challenges are significant obstacles to large multicentre randomized controlled trials. It is probably best to collaborate with international partners, in this regard. However, there is a growing awareness that size does not always matter, and a randomized controlled trial may introduce its own biases.[15] Where does that leave the average clinical researcher? In my opinion there is still significant value to be had from smaller, well-designed, focussed analytical research projects, especially in relation to innovative research fields where the principles and premises are not well established. Performing high-quality research that is based on excellent protocols that employ standardized international outcome measures will allow subsequent incorporation into meta-analysis, which in turn strengthens our evidence base. Ultimately, it is not necessarily the EBM principle that appears to be the major concern but the way we reach our conclusions.

> "....how simple it can be to manipulate a p-value by simply changing a variable"

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Hand Therapy in Romania

O.D OLARIU,. MSC.

Romania is situated in the south-east part of Europe. It was a communist nation after WWII, but has reformed to a Republic in 1991, with a multiparty political system, market economy and individual rights of free speech and religion. Romania is a full member of the European Union since 2007.

Hand Surgery and Therapy in Romania evolved 15 years ago through the hard work of Prof. Alexandru V Georgescu, MD, PhD, Head of the Department of Plastic Surgery, Cluj-Napoca Recovery Hospital. As a Plastic Surgeon with an interest in Hand Surgery and Therapy, along with devoted professionals from the field, the Romanian Society for Surgery of the Hand was established. A few years later, working with a young group of Plastic Surgery residents, Physiotherapists and other rehabilitation professionals, they developed the hand therapy specialty. In Romania, instead of the traditional separations between occupational and physical therapists, the therapists distinguish their professional boundaries by subtle didactic training differences to work in different specialties, such as in the field of rheumatology and neurology.

A team of hand surgeons and hand therapists was established in Romania in 2005 (led by Prof. Georgescu, seated, and Mr. Octavian, 1st from left)

The concept of a team approach in Hand Surgery and Therapy was introduced in the hospital under the leadership of Prof. Georgescu and his therapy team. He emphasises when training interns and therapists in his team the importance of comprehensive management covering both the pre- and post-surgical periods. Regular case discussions among the team are conducted to promote communication between surgeons and therapists. Therapists are also encouraged to attend operations in order to have a better understanding of the surgical techniques, protocol and post-surgical management. One of the benefits is early edema control and active mobilization which can be conducted in a safe manner with much better treatment outcomes.

> “The concept of a team approach in Hand Surgery and Therapy”

In 2005, the First International Course on Hand Surgery and Hand Therapy was held in Romania with invited foreign guests presenting the most updated protocols used worldwide. The course was held a further three times until 2010 when the FESSH Congress took place in Bucharest, the capital of Romania.
In March 2006, Mr. Octavian D Olariu was invited to join the Philadelphia Hand Meeting. He won the Dorothy B. Kaufmann Educational Scholarship for the development of hand therapy in Romania. In the same year, the Department of Plastic Surgery, Cluj-Napoca Recovery Hospital, won the Vargas International Hand Therapist Teaching Award in Romania.

Above: Judy Colditz and Octavian Orlariu, of Romania at the Philadelphia Hand Meeting in March 2006. Octavian was the invited foreign guest of the Meeting.

Octavian is working to develop Hand Therapy in Romania and presented at the Philadelphia meeting.

Mr. Octavian and Ms. Judy Colditz, ex-president of IFSHT at the Philadelphia Hand Meeting in 2006

Mr. Ocravian D Olariu is a qualified physical therapist who graduated in 2004 with a MS degree on chronic rehabilitation conditions. He has been practicing hand therapy for 15 years and is actively engaged in the management of the traumatized hand. He has won the Dorothy B. Kaufmann Educational Scholarship in 2006 for his contribution towards development of the therapy in Romania. He continues tp work closely with Alexandru V Georgescu MD to further develop Hand Therapy in Romania

CONTROVERSIES AND BEST PRACTICES FOR ACUTE SCAPHOID FRACTURE MANAGEMENT

Nina Suh and Ruby Grewal

Journal of Hand Surgery (European) January 2018 edition (Volume 43, Issue 1, p4-12)

1. What were your main reasons for writing this article?

Acute scaphoid fractures are common wrist injuries that continue to elicit debate from surgeons regarding the most appropriate diagnostic and management algorithms. The main reason for writing this article was to examine the current literature and trends in an attempt to provide the reader with an evidence-based discussion regarding current controversies of interest to clinicians. In addition, we attempted to provide recommendations for the best treatment practices for acute scaphoid fractures based on the current literature.

2. What are the most interesting/important results and conclusions of your article?

The most important conclusion of our study was that despite the abundance of literature on acute scaphoid fractures, there remains significant heterogeneity in management algorithms making comparisons of different studies difficult. Some of the most clinically relevant results were:

1. Early advanced imaging such as a CT or MRI within the first week of injury should be considered for high-demand patients who present with radial-sided wrist pain and negative radiographs and who wish to avoid unnecessary cast immobilization.
2. Inclusion of the thumb in a cast has not been shown to increase scaphoid union rates or accelerate time to union.
3. There is no conclusive evidence to favour one surgical approach over another, so surgeons should select the approach they are most proficient with and that provides the best visualization and fixation of the fracture. Furthermore, a single compression screw along the axis of the scaphoid is a supported method of fixation for scaphoid fractures.
4. Distal pole scaphoid fractures may be treated non-operatively with predictably high union rates and no long term negative sequelae while proximal scaphoid fractures should be treated operatively to maximize union rates and shorten time to union.
5. Controversy persists regarding the treatment of waist fractures with agreement in the literature that displaced waist fractures should be treated operatively to reduce the fracture and avoid development into non-union. However, consultation with the patient should be undertaken for non-displaced waist fractures, as the evidence from earlier operative intervention is encouraging for faster union times, earlier return to work, and increased cost-effectiveness. However, cast immobilization is also a viable treatment option based on more recent CT-based studies, with comparable union rates and time to union whilst avoiding operative complications. A CT to confirm stability before opting for casting and a CT to confirm union before cast discontinuation is recommended.

3. What should all hand surgeons (and or hand therapists) reading your article understand about the findings of your research?

All hand surgeons and hand therapists should understand that the findings of our research is based on the current evidence and, as such, is subject to change as new technological advances and research is added to the literature. However, we believe our article demonstrates the importance of not only taking the CT characteristics of the fracture into consideration, but also the physical demands and immobilization concerns of the patient before making a treatment decision.

4. Will you be conducting further research/ publishing further work on this topic? If so, what will it entail?

Yes, we will be investigating further into the impact of scaphoid fractures on the development of arthritis in the wrist. Our immediate research studies involve biomechanical investigations into scaphoid graft options and the impact of scaphoid morphology on arthritis development.

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Phalangeal neck fractures in children

TIPS AND PEARLS OF WISDOM

M. M. Al-Qattan

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For unknown reasons, phalangeal neck fractures in children have an unusual high incidence in Saudi Arabia. Being a Professor of Hand Surgery at King Saud University, I developed a special interest in these fractures and the classification of these fractures bears my name[1-17]. Frequently, I ask my trainees the following questions to teach them the tips and pearls of wisdom regarding the management of these fractures.

What is the essential radiological view for diagnosis of phalangeal neck fractures, and why?
A lateral X-ray is essential for determining the fracture type. The A-P X-ray view may even miss the presence of a fracture (Fig 1).

Fig 1. a) An A-P view shows what seems to be a greens stick undisplaced phalangeal neck fracture.
b) The lateral view shows the completely displaced fracture.

What is the classification of these fractures, and what do we mean by the "cap" fracture?
In 2001, Al-Qattan[1] classified these fractures into 3 types: Type I are un-displaced fractures. Type II fractures are displaced, but there is still bone-to-bone contact between the proximal and distal fracture fragments. The distal fragment is almost always dorsally displaced (Fig 2a). Al-Qattan[2] named it the "cap" fracture because the lateral view resembles a person with a pushed-up cap (Fig 2b). Type III fractures are displaced with no bone-to-bone contact between the two fracture fragments (Fig. 3).
In 2015, Al-Qattan[3] sub-classified type II fractures into four sub-types according to fracture line configuration (Fig. 4).

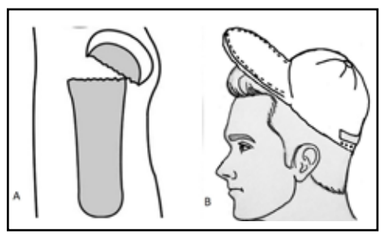

Fig 2. a) Type II fracture with the distal fragment dorsally displaced.
b) This resembles a person with a pushed-up cap.

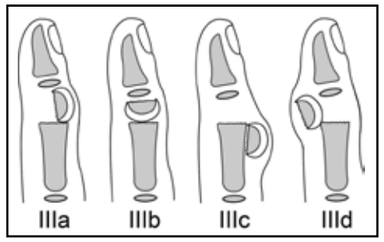

Fig 3: The 4 sub-types of type III fractures. Note that there is no bone-to-bone contact between the two fracture fragments.

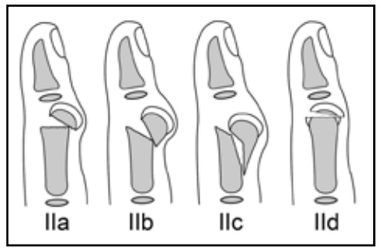

Fig 4: The 4 sub-types of type II fracture as per the extended Al-Qattan's classification.

What is the patho-mechanics of types IIIa and IIIb fractures?
These fracture types are only seen when the mechanism of injury is by entrapment of the digit in a closing door. The phalangeal head has no tendon attachments; and the head is held to the proximal epiphysis by collateral ligaments. The closing door separates the phalangeal head from the diaphysis. The child then withdraws the entrapped digit from the closing door. The created traction force opens up the space at the fracture site, allowing the phalangeal head to swivel to 90° position (Type IIIa). In a swinging door, the digit may be caught twice in the door, and the second withdrawal traction will then "swivel" the head from 90o to 180o[4]. A type IIIa fracture may be made into a type IIIb fracture by the emergency room physician who is attempting to do a closed reduction[18]. Excessive longitudinal traction converts the 90o rotation into 180° rotation.

What is the management of Type I fractures?
Phalangeal neck fractures are unstable. Hence, Type I fractures are treated with a full above-elbow cast in young children for 4 weeks. This ensures that the fracture will not be displaced.

What is the management of Type II fractures?
Type II fractures should be treated by closed reduction and K-wire fixation. Every effort should be made to avoid open reduction because open reduction is known to be associated with risk of stiffness and avascular necrosis. The "gentle pressure-flexed joint" technique is an effective closed reduction technique[3]. Under C-arm guidance, the finger joints are flexed and the surgeon then applies gentle manual pressure dorsally over the phalangeal head. If that fails to obtain reduction, a percutaneous K-wire is placed dorsally into the fracture site. The wire is then lifted-up to act as "joy-stick" or a "lever" to reduce the fracture (Fig 5), similar to the Kapandji technique used in distal radius fractures[19]. Once reduced, a K-wire is then inserted for fracture fixation. A stepwise algorithm for the surgical management of Type II fractures was recently published by Matzon and Cornwall[20].

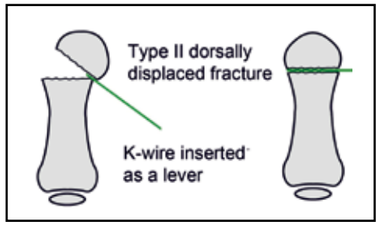

Fig 5: The 'joy stick" or "lever" technique for reducing type IIA fractures.

What are the surgical tips in Type II fracture management?

1. Every effort is made to avoid open reduction as mentioned above.
2. Always do the closed reduction in the operating room under C-arm guidance.
3. Always be "gentle"; vigorous attempts of closed reduction may result in commination of the fractured head[5].
4. Always use a thin K-wire. A thick wire may 'split" the head into two fragments.
5. Try to avoid multiple passes of the K-wire into the fractured head.
6. Try to avoid passing the K-wire across the joints in order to reduce the post-operative joint stiffness.

Hand surgeons may accept crossing the DIP joint with the K-wire because mild stiffness at this joint is well-tolerated.

Various techniques of joint-free K-wire fixation of phalangeal neck fractures are shown in Figure 6. The intramedullary pre-bent wire technique avoids the joints and this technique is inspired by the "bouquet" technique of Foucher in adult metacarpal neck fractures[21]. Crossed K-wires may be used in type IIA fractures; and oblique K-wires may be used in types II B/C fractures. For Type IIA fractures of the proximal phalanx of the fingers, Al-Qattan popularized the peri-articular technique. Al-Qattan obtained excellent results using this technique in paediatric and adult cap fractures[3,6,7] as well as transverse shaft fractures of the proximal phalanx[23,24] (Fig 7).

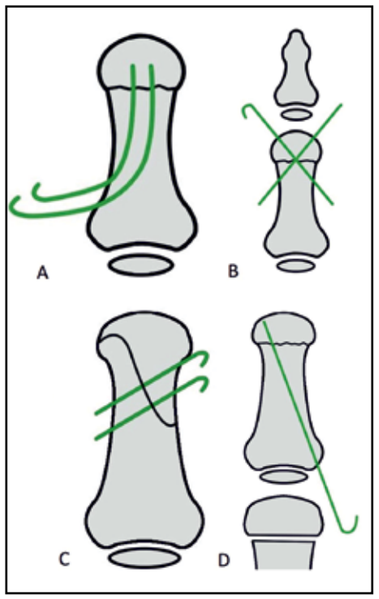

Fig 6: Joint free techniques of K-wire fixation of phalangeal neck fractures:

a) The intramedullary pre-bent wire technique,
b) The crossed K-wire technique,
c) Types IIb and IIc may be treated with oblique K-wires,
d) The peri-articular technique proposed by Al-Qattan for cap fractures of the proximal phalanx avoids passing across the MP and PIP joints.

Fig 7: An intra-operative view of a cap fracture of the proximal phalanx using the peri-articular technique. Note that the metacarpal head is spared and that the wire catches the sub-chondral bone of the fractured head.

What is the easiest and what is the most difficult Type II fracture to manage, and why?
Type II C with a "flange" is the easiest because the "flange" makes it easy to manipulate and fixation may be done through the flange (see Fig 6c). Type II D is the most difficult because the dorsal fragment is very thin and is usually seen in very young children. Manipulation and reduction are difficult and have a higher risk of iatrogenic comminution.

What is the management of Type III fractures, and why do they raise a "red flag"?
In phalangeal neck fractures, the phalangeal head is ischemic (the blood supply is only through the collateral ligaments). In all type III fractures (Fig 3) the collateral ligaments are either twisted or disrupted; and hence the risk of avascular necrosis of the fractured head is high. Types III C and D fractures are usually open fractures and may be associated with neurovascular injury. Fixation with K-wires is usually done through the existing laceration. Type III B and most Type III A fractures require open reduction through a dorsal approach.

What do we mean by troublesome phalangeal neck fractures?
In 2016, Al-Qattan[8] defined five criteria that will qualify the fracture to be regarded as "troublesome": vascular compromise of the digit, concurrent partial amputation of the fractured digit, the presence of phalangeal head commination, concurrent growth plate injury distal to the fractured head, and all Type III fractures. The outcome of management of these fractures tends to be poor and the risk of avascular necrosis is high.

Do mal-united phalangeal neck fractures remodel?
Although phalangeal neck fractures are located away from the physis, mal-united fractures may remodel[9] as shown in Figure 8. Cornwall and Waters[24] recommended the following criteria for taking the conservative wait-and-see approach in mal-united paediatric cap fractures: mal-alignment should be accepted only in the sagittal plane, congruent adjacent joints, and acceptance by the family to wait and to have regular follow-up for several months awaiting the remodelling.

Al-Qattan recommended explaining this to the parents (before surgery) and documenting the expected outcome and complications in the medical file for medico-legal reasons.

What are complications of phalangeal neck fractures in children?
Out of all paediatric hand fractures, phalangeal neck fractures are known to have the highest complication rate. These include: delayed union, malunion, nonunion, avascular necrosis of the phalangeal head, stiffness, digit deformity, partial resorption of the phalangeal head leading to deviation of the finger, resorption of the diaphysis (i.e. the proximal fracture fragment), iatrogenic comminution of the phalangeal head during closed reduction, iatrogenic splitting of the phalangeal head during the insertion of a large-sized K-wire, and the formation of a bony spur in the sub-condylar fossa leading to blockage of finger flexion[10-15,25].

Fig 8: a) The child presented to me 4 weeks after injury with malunion. b) Complete remodelling 5 months later with full range of motion.

In non-united phalangeal neck fractures, (without avascular necrosis) are bone grafts required?
Al-Qattan showed that preoperative examination of the digit determines the need for bone grafting in the management of non-union (without avascular necrosis) of phalangeal neck fraction. If the digit is flail, bone grafting is always required. In contrast, trimming of the sclerotic bony edges and K-wire fixation (without bone grafting) is sufficient to obtain union in non-flail digits with non-union [10-13,15].

What are the surgical tips of performing bone grafting for phalangeal neck fracture non-union in young children?
All papers published in the world literature on this topic were by Al-Qattan[10-13,15]. For unknown reasons, the thumb is the most commonly affected digit. As mentioned above, the presentation is a short flail thumb which is a major disability functionally and cosmetically. Furthermore, there is also no effective IP joint motion. The surgical tips are as follows: a) use a longitudinal mid-dorsal incision. b) remove the sclerotic edge of the proximal fracture fragment aggressively. In contrast, removal of the sclerotic edge from the phalangeal head is done very carefully with a curette or a rongeur; and do not perforate the articulate cartilage. c) there are two possible sources of bone graft: outer cortical calvarial bone graft[10] or iliac crest bone graft[11,13]. In young children, the

iliac crest has an apophysis which should be split and protected. d) first insert the K-wire retrograde into the distal fracture fragment to exit at the tip of the digit. Then push the K-wire antegrade through the bone graft, the diaphysis of the proximal phalanx and the metacarpal. e) the cortico-cancellous bone graft should fill up the bony defect snugly. However, do not over-stretch the thumb to avoid vascular compromise secondary to over-stretching of the neurovascular bundles. f) keep the wire for 6 weeks. g) only expect 5-10 degrees of motion at the IP joint at final follow-up. However, this does not affect parent satisfaction because the thumb length has been restored, and restoration of thumb stability greatly improves function. A demonstrative example is shown in Figure 9 a, b and c.

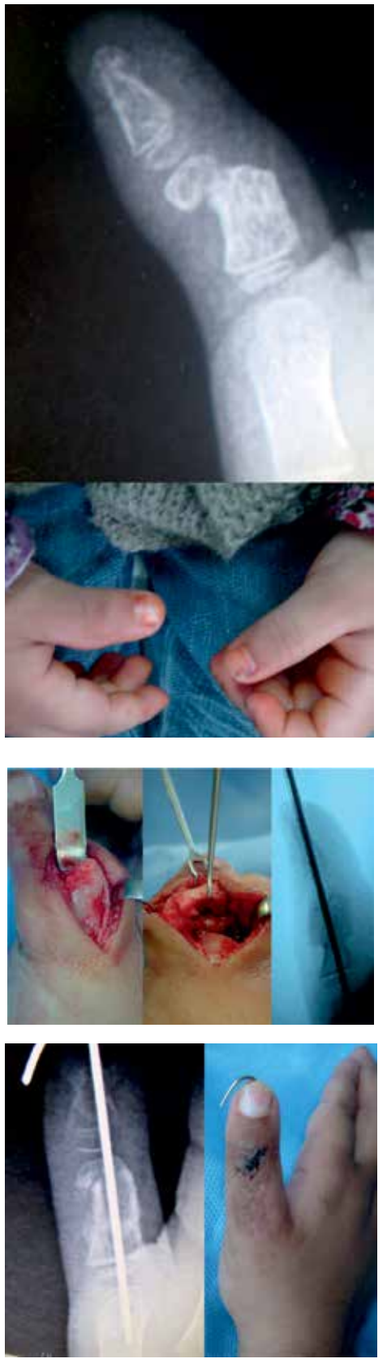

Fig 9 a,b,c Demonstration of bone grafting for non-union of a cap fracture of the thumb:

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Member Society News

ASSOCIATION OF CHINESE-SPEAKING HAND SURGEONS UNITED (ACU) AND THE FOURTH ANNUAL JIXIA HAND SURGERY FORUM

The Association of Chinese-speaking Hand Surgeons United had an annual Jixia Hand Surgery Forum and ACU Congress on 1-2 June 2018 in Jinan with over 500 attendees (Figures 1 and 2). The speakers and presenters to both events were from mainland China, Taiwan, Hong Kong and overseas. The two invited keynote lectures in the ACU meeting were given by Dr Roberto Adani from Italy and Chih-Hung Lin from Taiwan. The ACU meeting had free paper sessions, symposiums, and educational sessions.

Jixia, the name of the hand surgery forum, is derived from the Jixia Academy, a higher education institute established 360 BC in Qi (an ancient country of China) for free exploration and dissemination of knowledge and thoughts. Jixia had a forum for strident debates among the major schools of thought and displayed an agonistic ambiance equal to that in the Athenian schools of philosophy (about the same period as Jixia). The presenters to the fourth annual Jixia Forum in 2018 included groups of presenters from Shandong Provincial Hospital, Nantong University Hospital, Tianjin Hospital and Beijing Jishuitan Hospital, and attendees from many other hospitals. This year's forum started from 8 am, ended at 8 pm, non-stop except a few tea breaks. The meetings have strict regulations to ensure free and in-depth discussion with strict timing for each presenter or debater.

The Jixia Hand Surgery Forum had several featured sessions: wrist disorders, tendon repair, wide awake hand surgery, functional evaluation of the hand and microsurgical repair and reconstruction (Figure 3). The forum also has two sessions which were loved by all attendees: a free report session open to the attendees to discuss cases with slides or videos, as well as a debate session of 7 topics with participation by all attendees (Figures 4 and 5).
The motto printed on the badges of all attendees read: "In free, equal and academic pursuing atmosphere, let us learn together".

CANADIAN SOCIETY FOR SURGERY OF THE HAND (CSSH)

The Canadian Society for Surgery of the Hand (CSSH) was reborn from the previously known MANUS in 2016. Its inaugural meeting was held in conjunction with the Canadian Society of Plastic Surgeons (CSPS) meeting in the nation's capital of Ottawa. This first meeting brought together an all-star cast of speakers from the worlds of orthopaedic surgery, plastic surgery, and hand therapy. It was a tremendous success, even forcing a last-minute venue change to a larger room! This was followed by another outstanding line-up of speakers at the 2017 meeting in Winnipeg, including special guest Professor Oskar Aszmann from Vienna, Austria.

The most recent CSSH meeting was held in the picturesque mountain landscape of Jasper, Alberta. The scientific program did not disappoint, putting on display the collaborative approach to high-quality hand surgery knowledge dissemination that the society has become known for. Its objectives included improved patient communication strategies to decrease complication rates, technical alterations to get better results in hand procedures, and better post-operative rehabilitation protocols after hand surgery. The schedule featured Dr. Amitava Gupta from Louisville, and a number of young speakers from across the country. Once again, the meeting was a massive success, further building on the momentum from the two previous years.

The achievements of the society thus far have been a direct result of the incredible efforts that have been put forth by its executive. Dr. Paul Binhammer, the IFSSH representative and past president of the society, recently passed on the torch to internationally known Dr. Don Lalonde. President elect Dr. Avi Islur, secretary Dr. Heather Baltzer, and executive director Francine Dimambro round out the core group of individuals that currently lead the society.

The CSSH has already started planning the scientific program for the 2019 annual meeting and would like to extend an invitation to all members of the IFSSH, hand surgeons and hand therapists from around the world to join us on the East Coast of Canada in Saint John's, Newfoundland. June 25th, 2019 – save the date!

CHILEAN SOCIETY FOR SURGERY OF THE HAND

History
Organised hand surgery in Chile developed in the early 1950`s under the umbrella of the Chilean Orthopaedic and Traumatology Society (SCHOT) when the worker´s compensation law was passed and the Traumatology Institute created. The first hand surgeons and pioneers were Drs. Walterio Ihl and Victor Mouat. They developed and spread the knowledge and interest in Hand Surgery.

During the 1970´s the Hospital del Trabajador was established to provide treatment for work related injuries. Dr. Victor Mouat was the first director and soon this hospital became the 'mecca' for orthopaedic surgery and this resulted in attracting surgeons for the different specialities in orthopaedic surgery.

This picture was taken during the IFSSH Congress in Buenos Aires(2016)

Soon thereafter the first Hand Surgery Team was created under the leadership of Dr. Rossel. Other institutions where created for the treatment of work related injuries under the leadership of Dr. R. Gonzales and Dr. J. C. Uribe. These hand surgery teams trained most of the hand surgeons who later migrated to other hospitals spreading hand surgery all over Chile.

During the early 1990´s the South-American Hand Surgery Federation gave us tremendous support by organizing meetings. This enabled us to meet and befriend international hand surgeons. Many visits came from Drs. Eduardo A. Zancolli, Arlindo Pardini, Eduardo R. Zancolli, Walter Manna Albertoni, Jose Maria Rotella, Rames Mattar and Mario Rodriguez Sammartino, amongst many others. This led us to create the Chilean Society for Surgery of the Hand and subsequently our Society became an active member of the South-American Federation of Societies for Surgery of the Hand, as well as the International Federation of Societies for Surgery of the Hand.

During the early 2000´s while Dr. Alberto Perez was the head of the Hand Surgery Service at the Hospital del Trabajador and as a result of the international exposure, young surgeons began to spend time abroad learning skills such as microsurgery, arthroscopy and other techniques from renowned surgeons based at Nancy, Paris, Kleinert institute, Massachusetts General Hospital , Mayo Clinic, Hospital for Special Surgery in NY, Barcelona, Madrid, European Wrist Arthroscopy Society, Sydney and many other places, thus improving the knowledge, the interest and participation in our own and international meetings.

We are now a vibrant and growing National Society and a member Society of the South-American and International Federation with 300 plus members, participating in monthly meetings and an annual Congress. We hosted the South-American Federation Congresses in 2001 and 2015, which were presided by Drs. Alberto Perez and Jorge Vergara respectively.

Our current president is Dr. Juan Manuel Breyer and our IFSSH delegate is Dr. Lorena Parra.

The next annual meeting will be held in Santiago de Chile from 15 to 17 November 2018.

Everyone is welcome to participate and enjoy Chile!

The Chilean Society for Surgery of the Hand and Microsurgery

socimanochile@gmail.com

AUSTRIAN SOCIETY FOR SURGERY OF THE HAND

Hand Surgery in Austria

Austria has an notable position in the European history of hand surgery, mostly due to a number of dedicated internationally well-known Austrian hand surgeons. It was in the early twentieth century when Austrian surgeons recognized that specialized hand surgery education is essential to provide optimal care for hand injuries. The professional spirit and efforts have continued by Austrian surgeons up to this day.

Early contributors to hand surgery

Just to name some of these Austrian surgeons who contributed to hand surgery: Johannes Hartlieb (1400-1468) published the earliest German-written book of hand surgery “Buch von der Hand”. Simon Zeller (1746-1816) used a triangular dorsal flap to repair the interdigital space after syndactyly correction. Karl Langer von Edenberg (Ritter von Edenberg) (1819-1887) described Spaltlinien der Haut (skin ridges). Wenzel Leopold Gruber (1814-1890), an Austrian anatomist, published numerous works on anatomical variations of the hand, including the Martin-Gruber connection (connection of the ulnar and median nerve at the forearm). Carl Nicoladoni (1847-1902) reconstructed the thumb with pollicisation of toes and developed techniques for tendon transpositions. Robert Kienböck (1871-1953), a radiologist, described aseptic bone necrosis of the lunate. Ludwig Kirchmayr (1873-1928) developed a tendon suture technique in the hand, later known as Kichmayr repair. Arthur Steindler (1878-1959) performed elbow flexion plasty and tendon transpositions in the hand. Lorenz Böhler (1885-1973) gained worldwide fame with his work on fracture treatment and emphasized the dedicated care for hand injuries. He was one of the most distinguished personalities in Austrian trauma surgery. Josef Ender (1915-1980) published on the Ender plate and scaphoid plating. Otto Russe (1913-1983) performed scaphoid pseudarthrosis surgery, known as Russe bone grafting.

In the more recent decades, Jörg Böhler (1917-2005) completed the German translation of “Surgery of the Hand” written by Bunnell and founded “Wiener Handkurse”, a course series, that is still being held today. He was awarded “Pioneer of Hand Surgery” by International Federation of Societies for Surgery of the Hand (IFSSH) in 2001. Ernst Scharizer (1922-2009) was an editor of the “Handchirurgie” (changed in 1983 into “Handchirurgie, Mikrochirurgie, Plastische Chirurgie”). Emil Beck (1931-2001) published on surgical treatment of Kienbock disease, including transposition of a vascularized pisiform bone into the lunate bone (Beck’s procedure). Hanno Millesi (1927-2017) played a key role in peripheral nerve surgery, and was a co-editor of the “Handchirugie” and was awarded with “Pioneer of Hand Surgery” by the IFSSH in 1998, and was a founding member of the Austrian Society for Surgery of the Hand (ÖGH). Hildegunde Piza- Katzer (1999-2008) focused on the treatment of congenital hand deformities, and was awarded with the IFSSH title, “Pioneer of Hand Surgery” in 2013. Sigurd Pechlaner is a founding member of the ÖGH, with main interest in wrist trauma, and edited “Atlas of Hand Surgery”, was awarded with the IFSSH “Pioneer of Hand Surgery” award in 2016.

Hand surgeons in the Medical University Innsbruck performed a bilateral hand transplantation in a patient who sustained a bilateral hand amputation by a bomb in 2000. The procedure was conducted at the Plastic and Reconstructive Surgery Department led by Prof. Piza-Katzer and the Trauma Surgery Department led by Doz. Pechlaner together with the Department of Visceral, Transplant and Thoracic Surgery led by Prof. Margreiter. In Austria, a total of four bilateral hand or forearm transplantations have been performed thus far.

Clinical practice

In 2017 among 272 medical units in Austria taking care of 8,8 million inhabitants, four are FESSH certified Hand Trauma Centers where all hand trauma (including replantation) is treated by qualified hand surgeons. These hand trauma centers are geographically balance-distributed, with two in the east, one in the middle and one in the western part of the country.

In 2011 there were 6,1 million people insured with the government public accident insurance (population in Austria at that time was 8,4 Million). The government insurance is divided into four main sections: general trauma insurance company (Allgemeine Unfallversicherungsanstalt – AUVA), insurance for Austrian federal railway and coal organisation (Versicherungsanstalt für Eisenbahnen und Bergbau), insurance for government employees (Versicherungsanstalt öffentlicher Bediensteter) and insurance for farmers (Sozialversicherungsanstalt der Bauern). Besides these four, there are a few private Insurance Companies.

According to the AUVA report in 2011, 109,408 industrial accidents occurred in Austria. Of these, 38,6% affected the hand ie a total of 42,231 hand injuries in Austria during that year. The main injuries were wounds and superficial lesions next to fractures, dislocations, spraining. Most were located on one finger, the thumb, the metacarpal region and the wrist. The main mechanism of injury was contact with a sharp or pointed object like knifes, cutters, syringes, needles, glass and steel sheets. The overall costs

spent for the treatment of these hand injuries were 284,516,798 Euro. The average cost per injury was 6,737 Euro. These facts and costs led to the establishment of a committee for hand injury prevention consisting of insurance companies, medical doctors, representatives of the government and industry. The 3rd European Hand Prevention Congress took place in 2014 in Vienna. The aim was to establish ways to prevent hand injuries, and also in doing so, to reduce the high medical expenditures for the government.

Around 200,000 Austrians are affected by Dupuytren's contracture. The gold standard for the treatment is still partial fasciectomy. Since 2011 treatment with collagenase was offered all-over the country. To control the possible complications of the non-surgical treatment, the Austrian Society for Surgery of the Hand decided that only surgeons with experience with Dupuytren's surgery should use the collagenase. They would then be able to handle any possible complication. An Austrian wide registry was established in 2011 for the use and results of collagenase by the Medical University Innsbruck and the Austrian Society for Surgery of the Hand, and it is still on going. More than 800 patients are presently in this study and the long-term results, with the complications and the recurrence rate will be published soon.

Around 1% of Austria's population is suffering from rheumatoid arthritis. Hand surgeons with orthopaedic background treat most of these cases. Generally, since the introduction of Biologic agents, the rate of surgical treatment is decreasing.

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ARGENTINE SOCIETY FOR SURGERY OF THE HAND (AACM – "Asociación Argentina de Cirugía de la Mano")

The Argentine Society for Surgery of the Hand (AACM) had a year of intense academic activity and continuing medical education. Flowing from the Argentine and South American Conference in October 2017 in Buenos Aires, with 620 attendees, the new executive committee led by President Dr. Violeta Levy, General Secretary Dr. Jorge Boretto, Minutes Registrar Dr. Marcelo Mazzola, Financial Secretary Dr. Alvaro Muratore, and other participants, established a workgroup with the purpose of performing several activities of medical education for its associates and members of different Latin American Societies.

One significant step of our Society was the acquisition of a new venue. This venue was designed for the primary purpose of having a place to carry out attendance-based and virtual courses for our associates. The new office has a lecture hall with a capacity for 40 attendees, a touch screen (i3TOUCH 86" E series with high-definition images which operates at the touch of a finger or pen and reacts instantly) and a room specially equipped for webinars.

Academic activity and continuing medical education. Two courses on cadaveric specimens were carried out: one on lower limb microsurgery flaps for reconstructive surgery (Led by Dr. Levy, Dr. Boretto, and Dr. Muratore) and the other on upper limb peripheral nerve surgery (Led by Dr. Levy and Dr. Muratore).

In June, the AACM carried out an updating course which included a conference on WALANT surgery, with Dr. Donald Lalonde as a special guest, as well as other renowned specialists. This course welcomed 280 attendees.

In addition, two courses on advanced experimental microsurgery with rat models were also carried out (Lead by Dr. Garat and Secretary Dr. Boretto). This activity has been taking place since 2010 and has always received physicians, not only from all parts of our country but also from different Latin American countries (Colombia, Brazil, Chile, Peru, Bolivia, and Uruguay).

Since 2007 the AACM has committed itself to reach different provinces in Argentina and to carry out two or three Regional Congresses. This year these congresses were held in the province of La Pampa with Dr. Mauro D'Adam as regional coordinator and in the province of Catamarca with Dr. Carlos Gonzalez as regional coordinator.

Three webinars, coordinated by Dr. Gustavo Teruya, were also carried out which included foreign and national distinguished guests such as Dr. Luis Shecker (USA), Dr. Lorena Parra (Chile), Dr. Eduardo Zancolli, Dr. Sergio Daroda, Dr. Gabriel Clembosky, Dr. Carlos Zaidenberg and Dr. Juan Carlos Cagnone.

Finally, our annual congress will be held in October 2018 and is organised by President Dr. Cecilio Argañaraz and Secretary Christian Perrotto. Foreign guests will include Dr. Andrea Atzei, Dr. Alex Lluch, and Dr. Luiz Franciosi.

D.G. Carla M. Cometto
AACM Secretaría Curso de Junio y Congresos

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COLUMBIAN ASSOCIATION FOR SURGERY OF THE HAND

On 1 July 1966, 29 dedicated Hand Surgeons created the first Hand Surgery Society in Columbia. This Society was founded to create more awareness for the need of Hand Surgeons. Dr. Paul W. Band was instrumental in the establishment of our Society. In 1997 however, due to Colombian government laws, the name was changed from Society to Association.
The first Hand Fellowship program was created by the Military University Medical Faculty. This one year fellowship was aimed at Orthopedic or Plastic Surgeons who wanted to specialize in Hand Surgery, and was offered at two Bogota hospitals, the San Rafael Hospital Clinic and the Central Military Hospital.

Dr Paul Brand and Dr Roberto Laignelet Rueda with a patient.

Dr. Jochen Gestner published multiple articles, including, 'Primary care and rehabilitation' in 1980. With the help of Dr. Andres Echeverri he also wrote 'Concepts of Traumatology'. Dr. Felix Borreto published 'Hand Traumatology' in 1996. Dr. Felipe Coiffman translated and published in 1962 the work of Dr. Arthur Joseph Barsky's first edition of 'Congenital Anomalies of the Hand and their Surgical Treatment' written 1958. He translated Dr. Bernard McC O'Brien's publication of 'Microvascular Reconstructive Surgery' which was published in 1980. Dr. Coiffman also published in 1986 the first edition of 'Plastic Surgery, Reconstructive Surgery and Cosmetic Surgery'. In 2008 the 3rd edition in 6 volumes was published. One of these volumes was dedicated to 'Hand Surgery and the Upper Limb'. In 2006 Dr. Julio Bermudez and Dr. Francisco Camacho published a manual for 'Microsurgery Technique' with the help of the Universidad del Bosque. Dr. Roberto Melendez published a book called 'Hand Surgery – Essential aspects for clinical practice' in 2014. Also in 2014, Dr. Enrique Vergara, president of the Columbian Association at the time, was the editor of a book commissioned by the Association on injuries of the hand, which included 16 surgeons and 2 physical therapists as authors.

The Association published a second book in 2015 with the title 'Tendinitis and Tendinosis of the Elbow, of the Hand and associated injuries'. Sixteen members and 2 correspondents worked on this book. On 2017 a 3rd book was published: 'The Carpal Scaphoid', with editors Dr. Roberto Melendez and Dr. Fabio Suarez. Twenty-one authors worked on this book including 1 physical therapist. Dr. Jaime Restrepo has made notable contributions on micro-vascular anatomy research, especially of the fibula.

From 22-25 August 2018 our Association will hold its National Congress in Medellin with 16 international speakers. Also, during August the South American Congress on Hand Surgery will take place in Cartagena.

We will fully participate in the IFSSH Congress in Berlin next year and will also bid to host the 2025 IFSSH Congress in the city of Cartagena, Columbia.

BRAZILIAN SOCIETY FOR SURGERY OF THE HAND (SBCM)

The Brazilian Society for Surgery of the Hand (SBCM) was founded in 1959 by 57 hand surgeons. Currently, we have more than 700 members and it is one of the largest Members Societies of the IFSSH.

The SBCM has almost seventy years of history and, from the outset, is committed to hold national and international events and courses, contributing important international scientific knowledge at meetings, as well as publishing in journals and hand surgery books. SBCM has 31 training centers for Hand Surgery in Brazil.

Since 2017, the Brazilian Society announced its intention to be the host country for the "2025 IFSSH Triennial Congress" which, accordingly to the rule of rotation, should be held in a country of the American continents.

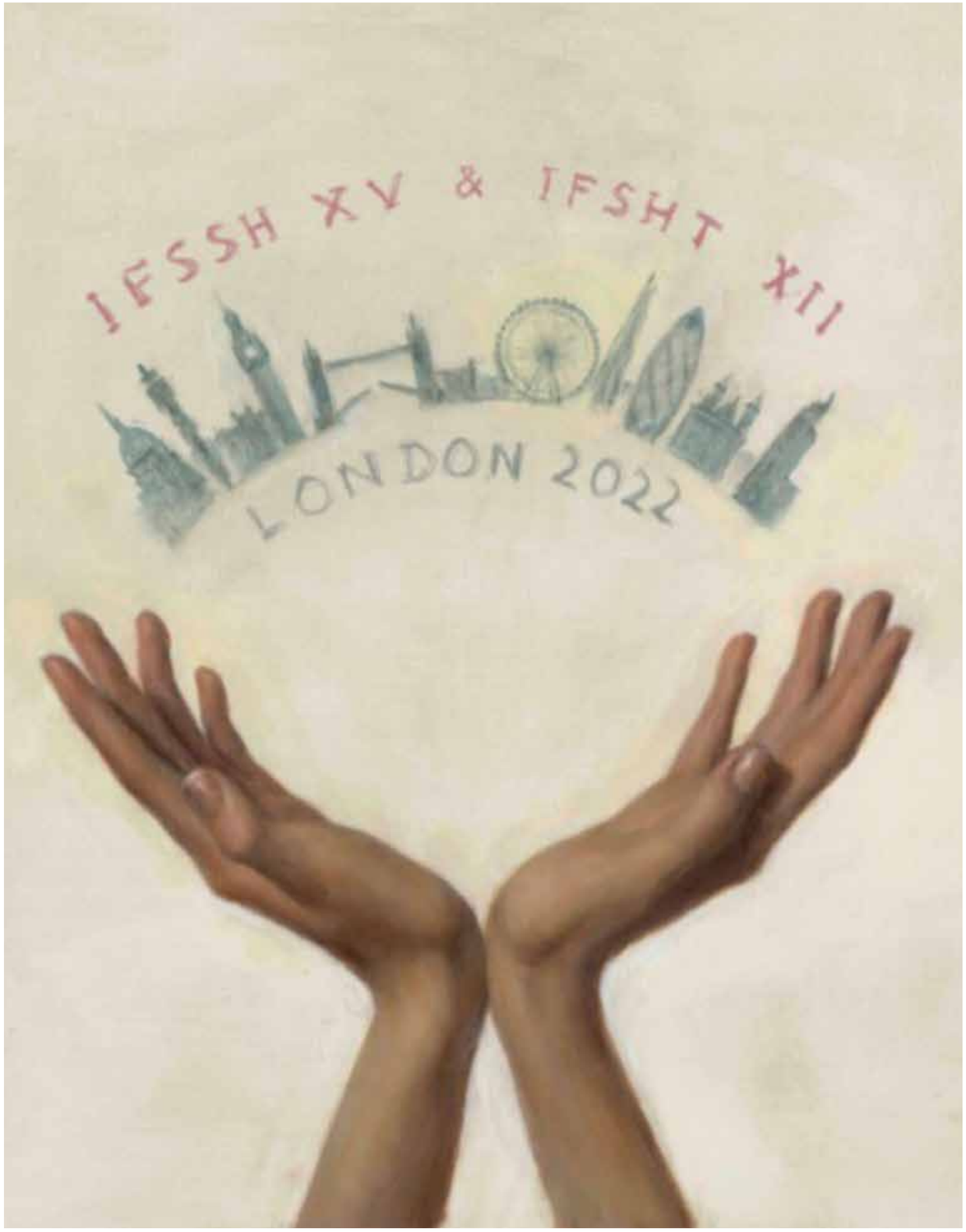
The Brazilian Society was represented by a large delegation of members at the FESSH 2018 Congress in Copenhagen.
The Brazilian Hand Surgeons participated in the scientific program with 43 presentations among lectures and posters, and the SBCM again presented Brazil as a candidate to host the IFFSH Congress in 2025.

The general public is also the focus of the Brazilian Society. Every year it develops national and regional awareness programs on pathologies that affect hands. The last one was about preventing fireworks accidents, very common during regional festivals in June and the Soccer World Cup.

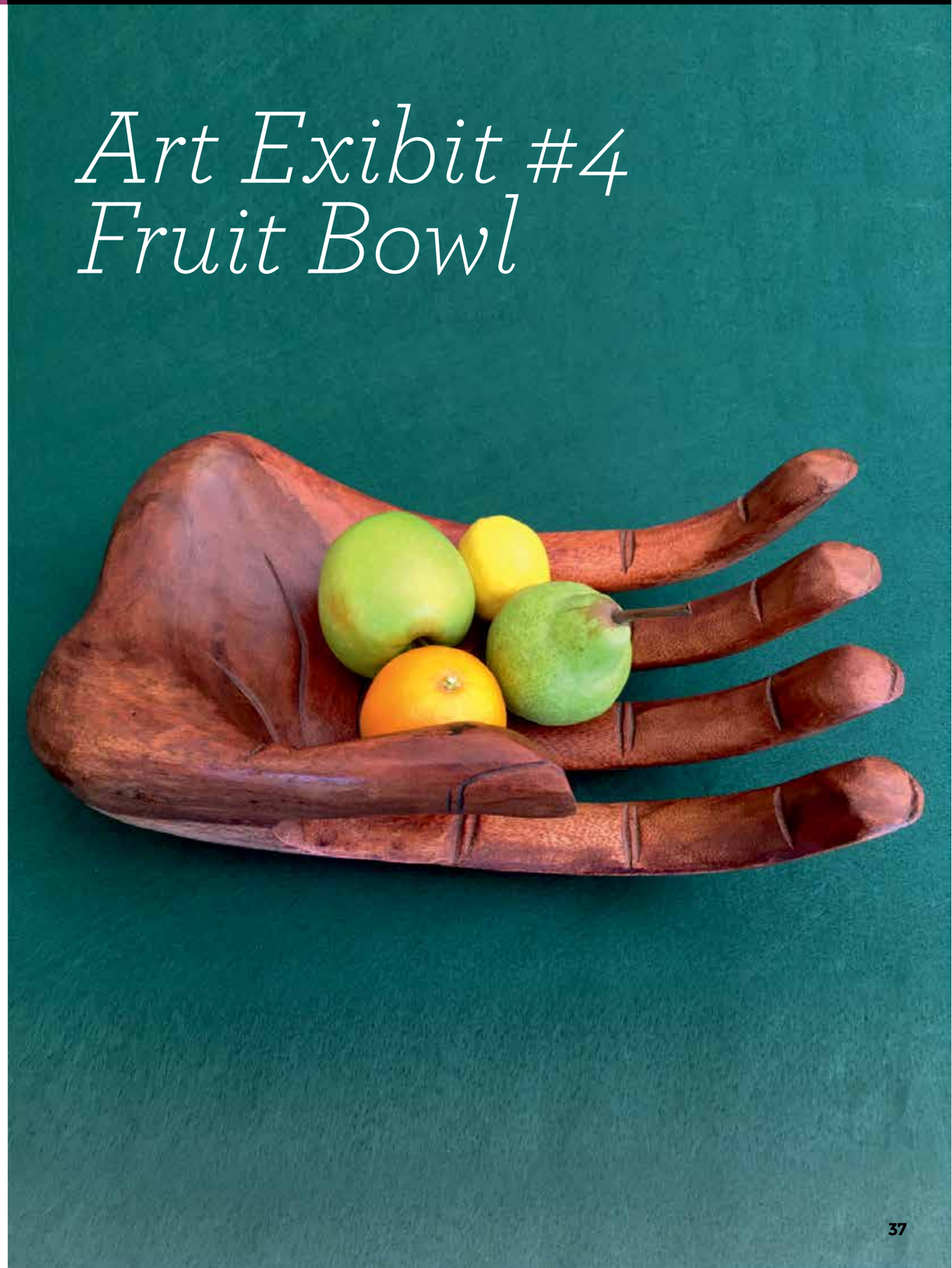
Our Society will host its 38th Brazilian Congress of Hand Surgery on 16-18 August 2018, in Fortaleza, Ceará, Brazil. SBCM President Milton Pignataro, Congress President Marcelo Rosa de Rezende and Honorary Congress President Ronaldo Jorge Azze have developed a rich and varied program for the event, focusing on arthroscopy and congenital deformities.

To learn more about the Brazilian Society for Surgery of the Hand, visit the website:
SBCM - Sociedade Brasileira de Cirurgia da Mão
www.cirurgiadamao.org.br

SBCM
Sociedade Brasileira de Cirurgia da Mão

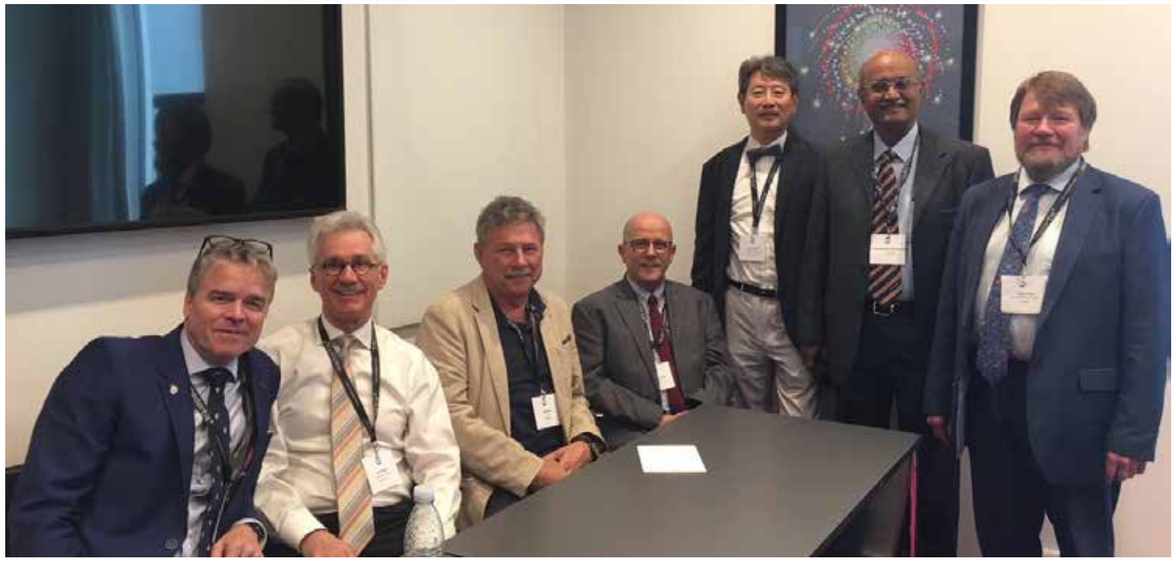


Art Exibit #4 Fruit Bowl



IFSSH Exco and Delegates Council Meeting

JUNE 2018, COPENHAGEN, DENMARK



International Course on Supermicrosurgery

Dear Colleagues,
On behalf of the scientific program committee, It is our pleasure to invite you to the International Course on Super-microsurgery (ICSM) which will be held on 12-14, October 2018 at the Shangri-La International Hotel, Jinan, China.

The preliminary panels of the ICSM meeting will include:

- Hand and upper extremities
- Lower extremities
- Brachial plexus
- Facial reanimation
- Neuropathy of upper and lower extremities
- Micro lymphatic
- Breast reconstruction
- All kinds of replantation (extremities, ear, nose, scalp, penis, and scrotum....)
- All kinds of vascularized tissue allotransplantation and related (face, hand, penis, uterus, larynx, head, hepatic artery...)
- Special flaps (super-tiny, super-huge, super-thin...)
- Non-physiologic flap (venous flap, puzzle flap...)
- Special tricks to salvage the circulated compromised flap
- Medical education and social media
- Clinical anatomy of microsurgery
- Special techniques in microsurgery
- The limit of the Microsurgery (longest and shortest time)
- Deceptive reconstruction
- Hi-Tech involved (3D printing, virtual reality, artificial intelligence)
- Laboratory microsurgery
- Robotic microsurgery
- Cosmetic Microsurgery
- Pediatric Microsurgery
- Microsurgery in aged patients
- EV-IC bypass
- Esophageal reconstruction
- Trunk and Torso reconstruction
- Perineal Reconstruction
- Other special topics of supermicrosurgery

A special panel about Difficulties Facing Microsurgery Practice in Developing Countries will discuss the situation in 8 countries: Egypt, Sudan, Morocco, Nepal, Kyrgyzstan, India, Nigeria and Pakistan

Detail of the free paper section will be announced on the website later.

A shuttle bus will be available for transportation from the airport to the hotels.

The official website: mhttps://www.2018icsm.com
The official Facebook page: https://www.facebook.com/2018icsm/
The Facebook event page: mhttps://www.facebook.com/events/488653204883868/

Please forward this information to all your colleagues. Feel free to contact us if you have any further inquiries or suggestions.

Looking forward to seeing you at our meeting and eagerly awaiting for your participation.

Best regards,
Usama Farghaly Omar, MD, M.Sc.
Orthopedic Surgeon, Al-Hekma Specialized Hospital, Assiut, Egypt.

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INVITADOS
EXTRANJEROS

Dr. Andrea Atzei (ITALIA)
Dr. Alex Lluch (ESPAÑA)
Dr. Luiz Franciosi (BRASIL)

TRABAJOS LIBRES Y POSTERS
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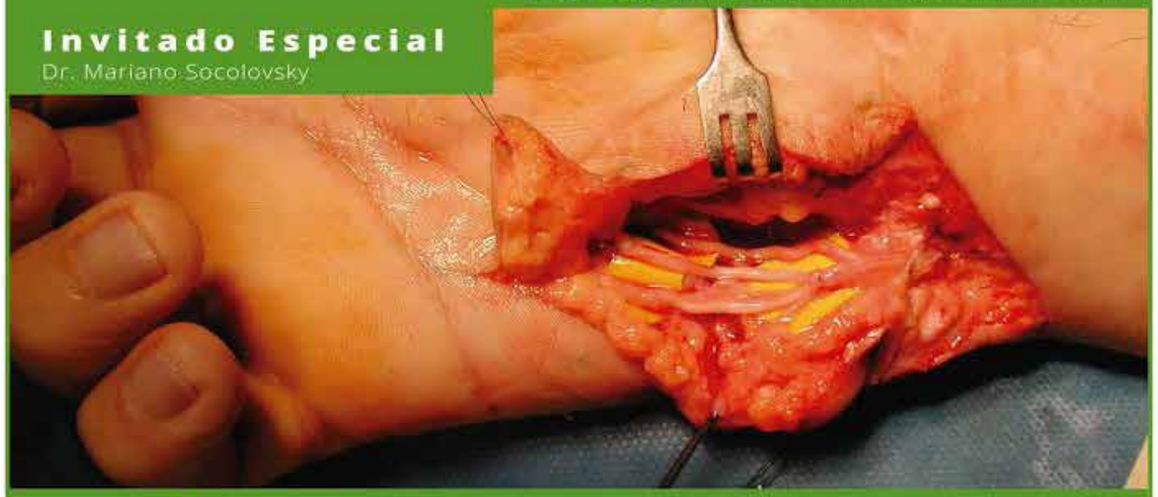

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