

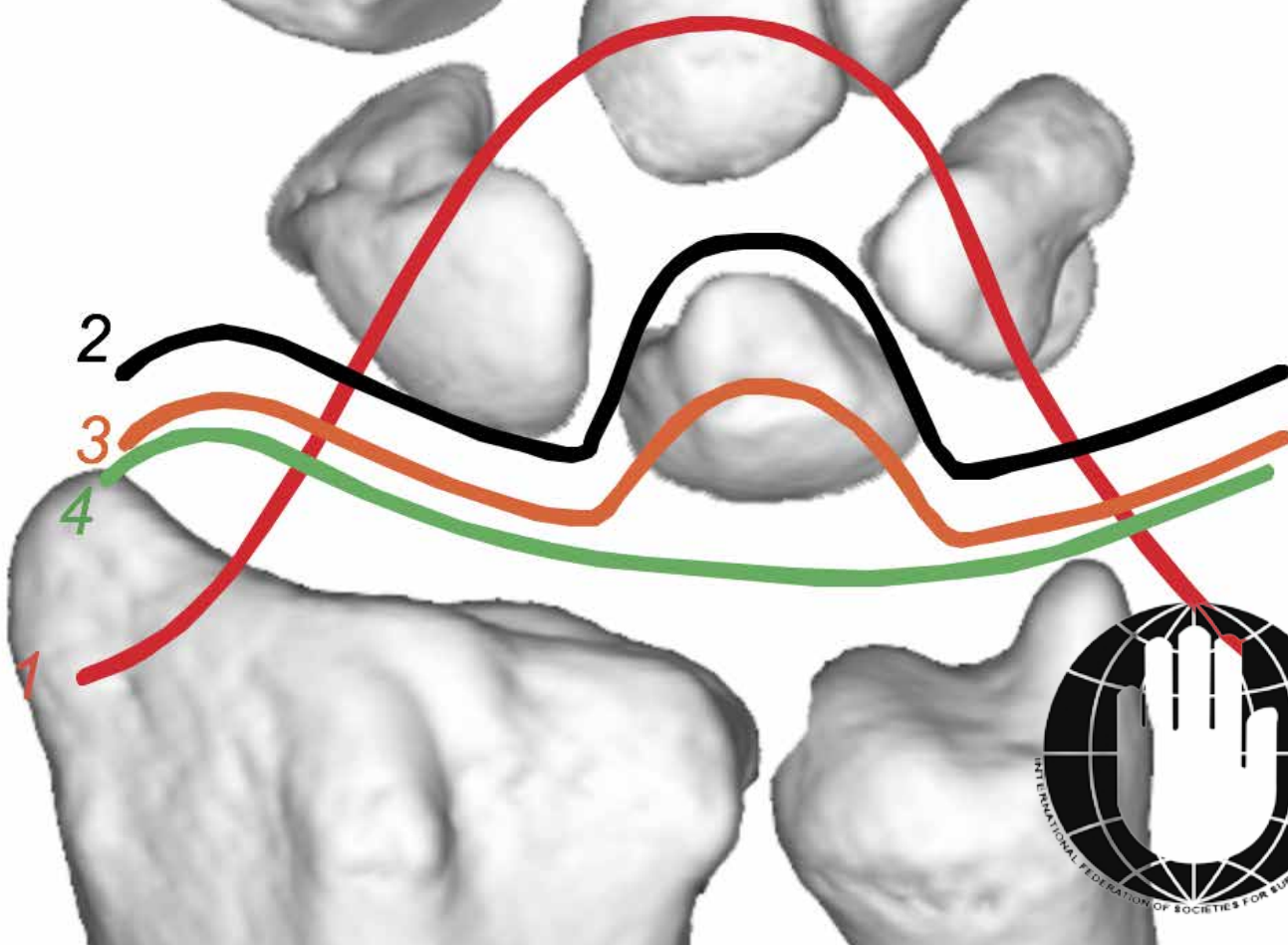
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CONNECTING OUR GLOBAL HAND SURGERY FAMILY

IFSSH
SCIENTIFIC COMMITTEE
ON CARPAL INSTABILITY - PART I

HAND THERAPY
VISIT TO KOMFO ANOKYE
TEACHING HOSPITAL

Scientific Committee Report Carpal Instability



HOW LONG CAN THE SURGERY FOR
THE PEDIATRIC TRIGGER THUMB BE
DELAYED?

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HAND SURGERY

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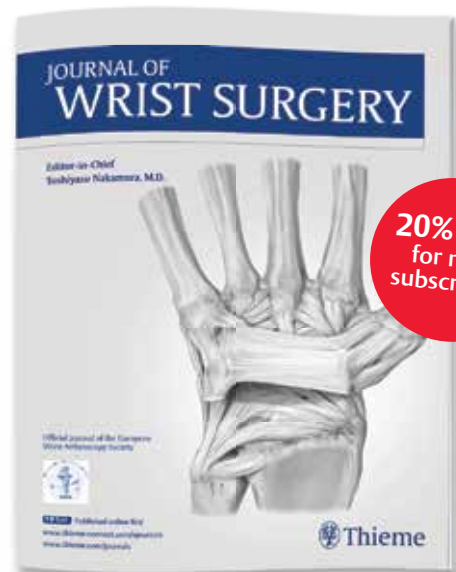
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4 EDITORIAL

Training in Hand Surgery: a personal view

- Michael Tonkin

6 SECRETARY-GENERAL REPORT

IFSSH Newsletter

- Daniel Nagle

8 OBITUARY

• W. Bruce Conolly

10 PIONEER PROFILES

• Giorgio A Brunelli

• Donal M. Brooks

12 SCIENTIFIC COMMITTEE REPORT

IFSSH Scientific Committee on Carpal

Instability

23 LETTER TO COLLEAGUES

CHULM

24 HAND THERAPY

Visit to Komfo Anokye Teaching Hospital

28 RESEARCH ROUNDUP

How long can the surgery for the pediatric trigger thumb be delayed?

- Goo Hyun Baek

30 PEARLS OF WISDOM

- Scott Oishi

32 MEMBER SOCIETY UPDATES

- Canadian Society for Surgery of the Hand
- American Association for Hand Surgery
- British Society for Surgery of the Hand
- American Society for Surgery of the Hand
- South African Society for Surgery of the Hand
- Switzerland Society for Surgery of the Hand
- Taiwan Society for Surgery of the Hand
- Turkish Society for Surgery of the Hand
- Venezuelan Society for Surgery of the Hand

40 JOURNAL HIGHLIGHTS

- Journal of Hand Surgery (European)
- Journal of Hand Surgery (American)
- Journal of Hand Surgery (Asian-Pacific)
- Journal of Hand Therapy
- Journal of Wrist Surgery
- Hand Clinics

48 UPCOMING EVENTS

List of global learning events and conferences for Hand Surgeons and Therapists

Training in Hand Surgery: a personal view

This is a subject which deserves the attention, from time to time, of those of us who teach hand surgery. Some history is pertinent, as it is only with an understanding of how we arrived at the present can we anticipate and create the future. However, this editorial is not intended to be a chronological nor a complete documentation of the development of hand surgery.

I begin, as many in the western world do, with Sterling Bunnell. Norman Kirk, the US surgeon-general during the 2nd world war, saw the need to develop centres in the US to manage the horrific upper limb injuries sustained in that conflict. From the nine centres organised by Bunnell came those pioneer surgeons who formed the American Society for Surgery of the Hand (ASSH) in 1947. Of course, many other individuals: British, Europeans, Scandinavians, and those from the many reaches of the Middle East and Asia were involved in hand surgery before this great advance in its structure, but it suits the purpose of this essay to begin here.

Hand surgery societies followed in other countries. The International Federation of Societies for Surgery of the Hand (IFSSH) was founded in Chicago in 1966 and now houses the societies of 56 countries. We celebrated our 50th birthday in Buenos Aires in 2016. Many of these societies have a close affiliation with orthopaedic surgery groups, many with plastic surgery groups and some with general surgery groups.

Nevertheless, there has been a natural tendency for societies to attract members from disparate surgical backgrounds because of their common interest in conditions pertaining to the hand.

The advent of the microscope and improvement in microsurgical instruments, sutures and techniques in the 1960s and 1970s provoked a flowering of innovation which had a particular influence on hand surgery, with revascularisation of devascularised parts, replantation of digits and limbs, increasingly sophisticated nerve reconstructions, and transfer of body parts as flaps becoming possible. These procedures, at least in the western world, tended to fall within the domain of the plastic surgeons; fractures, sprains and the like were more likely to be treated by orthopaedic surgeons; although limb trauma was treated in some European countries, such as Germany, by general surgery units.

However, in the 1980s and 1990s there developed the concept of 'a hand surgeon' able to treat the hand in its entirety – the skin and its contents, and the structures which control hand function, nerves, vessels, and musculotendinous units. How best to train such a person and how to convince the senior specialties that such a person was necessary? For just as general surgeons attempted to protect their realm from the breakaway orthopaedic surgeons, so do orthopaedic, plastic and other surgical groups prefer to avoid the development of independent sub-specialty groups.

The one team treats all approach negated the need to accumulate multiple surgeons together in time and place, and allowed the institution of complete early repair of all structures, rather than fragmented, piecemeal care. To this day, it remains unfortunate that the latter is still rationalised by some, for convenience.

Some countries have embraced training schemes for hand surgery, Singapore being one amongst others. In 2004, the Australian Hand Surgery Society (AHSS) proposed a programme with one year of general orthopaedic training, one year of general plastic surgery training and three (or four) years in hand surgery posts. In turn, the AHSS guaranteed posts for orthopaedic and plastic surgery trainees who wished to practise in one or other senior specialty, whilst also gaining the expertise to manage hand surgery problems to a certain level of sophistication. The senior specialties and the Royal Australasian College of Surgeons chose to not approve this proposal, favouring the not dissimilar systems of the UK and USA, where hand surgery training follows either orthopaedic or plastic surgery training and is supported by certification. In Europe, a hand surgery diploma has been introduced. Some countries provide a formal hand surgery curriculum, without the need to spend time gaining expertise in spinal surgery or breast surgery, to select two components of orthopaedic and plastic surgery which will be of little or no benefit to the specialist hand surgeon, whilst depriving those who wish to work in these areas of vital experience.

If anything, there has perhaps been a move away from the concept of the hand surgeon treating all parts of the hand anatomy. The concept of the orthopaedic upper limb surgeon treating the shoulder, elbow and wrist, with an emphasis on elegant arthroscopic technology, has taken hold. This is very much, though not absolutely limited to, the field of an orthopaedic surgeon. A plethora of shoulder/elbow, wrist and arthroscopic associations and societies

are flourishing. In the meantime, whilst some aim to proceed to hand surgery or other sub-specialty fields through the plastic surgery pathway, many plastic surgery trainees trend towards a future in cosmetic surgery. Perhaps market forces in capitalist countries may create an adequate balance.

So where does this lead us? In my opinion there is a place for the upper limb orthopaedic surgeon, trained through the orthopaedic pathway with access to specific hand/wrist surgery training; just as there is a place for a general orthopaedic or plastic surgeon with an interest in hand surgery, trained through the respective pathways and with access to specific hand surgery training. These positions are a reality in much of the developed world. Primarily, I believe that there is a place for the hand surgeon trained to deal with the skin and its contents: a microsurgeon, an orthopaedic surgeon, a plastic surgeon, a neurosurgeon and a vascular surgeon of the hand, in one. It is not beyond our wit, nor our prejudices and self-protective instincts to achieve this. Armed with such expertise we create those who are capable of establishing the next level of hand surgery care in developed countries and who are best positioned to assist developing countries to improve the standard of care for their patients.



Michael Tonkin
Immediate Past
President: IFSSH
Deputy Editor:
IFSSH Ezine

IFSSH Newsletter

It is a great honor and privilege to serve as Secretary General of the IFSSH. I follow in the footsteps of Dr. Marc Garcia-Elias, our current President Elect, who did an outstanding job as Secretary General. I will endeavor to continue this tradition of excellence. Fortunately I will have Ms. Belinda Smith, our very able Administrative Assistant, to assist and guide me.

The IFSSH is a unique organization dedicated to hand surgery education throughout the globe. The education of hand surgeons and hand therapists has had and will continue to have a significant impact on the well being of millions of people around the world. The IFSSH through its Committee for Educational Sponsorship (CES) is eager to financially support the development of programs, courses and other educational venues and opportunities. We will address this in more detail in future Ezines.

Finally, I believe accurate communication is extraordinarily important to achieving the mission of the IFSSH. It is not difficult to send an email but to send an email that is clear, concise and unambiguous takes some thought. I will always endeavor to abide by this precept. If ever I do not achieve this goal please let me know. I look forward to an exciting three years as your Secretary General. Thank you for the privilege.

IFSSH Triennial Congress Rotation

At the 2016 Delegates' Council Meeting, the IFSSH ExCo advised of some difficulties with the congress host rotation schedule, due to an over-direction of successive congresses to the Asia-Pacific region (Australia in 2007, Korea in 2010, India in 2013). This biased the geographic balance of congresses and the IFSSH ExCo has worked for a number of years on a formula to provide fair and even distribution of the international congresses. This includes the number of societies within each region, as well as the membership numbers within each of those societies. Competition to host a congress is increasing, and more societies may be interested as the membership numbers continue to grow.

To avoid any further confusion over the long-term schedule, the IFSSH ExCo announced the regional rotation until 2037, as follows:

- 2013 - Asia (Delhi, India)
- 2016 - Americas (Buenos Aires, Argentina)
- 2019 - Europe (Berlin, Germany)
- 2022 - Europe (subsequently awarded to London, United Kingdom)
- 2025 - Americas
- 2028 - Asia
- 2031 - Europe
- 2034 - Asia
- 2037 - Europe

The ExCo reported that the circumstance of two successive European congresses (2019 and 2022) is not optimal and will not be repeated. The ExCo will discuss the impact of these meetings with the congress hosts and FESSH to ensure all outcomes are considered.

The guidelines to place a bid for hosting rights are on the IFSSH website - <http://ifssh.info/guidelines.html>.

Future Meetings

A detailed list of national and regional hand surgery meetings is available on the IFSSH website.

The triennial IFSSH Congresses are as follows:

XIVth IFSSH – XIth IFSHT Congress – Berlin, Germany
20-24 May, 2019
www.ifssh-ifsht2019.com

XVth IFSSH – XIIth IFSHT Congress – London, United Kingdom
2022 - Dates to be confirmed

Best regards,



Daniel J. Nagle MD

Daniel Nagle MD
Secretary-General, IFSSH



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W. Bruce Conolly

1st February 1935 - 21st February 2017



A history of Bruce Conolly's life, his achievements and awards, give us an insight to the quality of the man and the surgeon. He was born in a New South Wales country town, son of a General Practitioner, Dr William Conolly, founder of the Royal Australian College of General Practitioners, and Ruth (nee King).

After graduating from the University of Sydney Medical School, Bruce spent three years in the United Kingdom training in general surgery, returning to Sydney as a senior surgical registrar at Sydney Hospital in 1965-66, before spending two years in the United States with Dr E. Kilgour and subsequently Dr Robert Carroll at the Colombian Presbyterian Hospital in New York. Bruce returned to Sydney Hospital in 1969 as a general surgeon, establishing a hand unit within that hospital. From 1972, Bruce Conolly concentrated his work exclusively on surgery of the hand. The Sydney Hospital Hand Unit was perhaps the first of its kind in Australia. Ian Isaacs and Tim Herbert were but two of many Australian hand surgeons who have worked with Bruce in that unit.

Bruce Conolly was appointed as Associate Professor of Hand Surgery at the University of New South Wales in 1992, Clinical Associate Professor of Hand Surgery at the University of Sydney in 1993, and Adjunct Professor at University of Notre Dame in 2011. He was President of the Australian Hand Surgery Society from 1995 to 1997,

and President of the Asian Pacific Federation of Societies for Surgery of the Hand from 2009 to 2012. Other awards include:

- Appointment to Member of the Order of Australia in 1994
- The Archie Telfer Prize for Outstanding Service, Sydney Hospital, 1975, 2000
- Humanitarian of the Year Award, Variety Club, 2002
- IFSSH Pioneer in Hand Surgery, 2007
- Royal Australasian College of Surgeons Award - Excellence in Surgery, 2008

Bruce published six texts relating to hand surgery and therapy and 85 publications. He was an honorary member of the Australian Hand Surgery Society and the British Society for Surgery of the Hand. This history gives an indication of Bruce's dedication and devotion to a life of hand surgery. It says little of the humanity which was a major force in all that Bruce did. He worked in more than 20 overseas countries from 1975 to 2012, in Africa, the Middle East, the Indian sub-continent, Pacific Islands, Papua New Guinea, and most South East Asian countries. He began a hand surgery training programme in Vietnam in the early 1990s with the support of Mosman Rotary and his colleagues at Sydney Hospital Hand Unit, along with hand therapists and nursing staff from that institution. Over the last 10 years or so he had a close association with the delivery of medical care in Myanmar, founding in 2013 the Myanmar-Australia Conolly Foundation for Health. He was of a profound religious faith.

Throughout Bruce's career he has been admirably supported by his wife, Joyce, and children, John, Christine and Bruce. Our heartfelt sympathy and love are extended to them. We say vale to a champion hand surgeon and an outstanding man.

Members and friends of the Australian hand surgery community.

May 2017



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When it comes to medical research, development and surgical training, experts agree that the use of human tissue is far safer and superior to textbooks, computer simulations or artificial substitutes. In the field of hand surgery, many advancements, including the world's first pediatric bilateral hand transplant, can be attributed to hours of research, training and practice using cadaver tissue.

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GIORGIO A BRUNELLI, MD



Giorgio Brunelli was born in 1925 in Cellatica (Brescia, Italy), and graduated from the University of Parma Medical School in 1949. Dr. Brunelli did his speciality training in orthopaedic and plastic surgery, physiokinesiotherapy and radiology. He received a *honoris causa* Doctorate from the University of Breslau, Poland, in 1988. He was Professor of Orthopaedics and Head of the School of Specialization in Orthopaedics and Hand Surgery at the Brescia University Medical School until 1997.

Professor Brunelli has been on the cutting edge of orthopaedic and hand surgery in Italy where he organized the specialties of hand surgery in 1952 and of microsurgery in 1964, performed the first total hip replacement in 1964, and the first re-implantation in 1973. He has developed many surgical techniques and

performed around 25 000 operations including 1 000 brachial plexus repairs. He has been doing research on paraplegia for more than 20 years and had the first paraplegic patient walking in 1997.

He has been a visiting professor and lecturer in many countries and has authored over 420 publications, including seven monographs, eight textbooks and 30 book chapters. He is a member of 28 scientific societies and Honorary Member of the Società Italiana di Chirurgia della Mano, and of the British, Australian and Venezuelan Societies of Hand Surgery. He is Founder Member of the Società Italiana di Chirurgia della Mano, Società Italiana di Microchirurgia, International Society of Reconstructive Microsurgery, Groupe d'Etude des Nerfs, and the International Society of Microsurgery. He is Past-President of Le Groupe pour l'Avancement de la Microchirurgie, Confédération Européenne des Services d'Urgences de la Main, International Society of Microsurgery, Honorary President of the Società Italiana di Microchirurgia, and President of the Association for Research on Spinal Cord Lesions. In 1980 the "Giorgio Brunelli Foundation for the Research on Spinal Cord Lesions" was established in Brescia, Italy.

Giorgio was President of the International Federation of Societies for Surgery of the Hand from 1995 to 1998.

Giorgio is married to Dr. Luisa Monini, a hand surgeon who participates in his work and research. They have five children, two are also hand surgeons. Giorgio's artistic excellence is demonstrated in his paintings (personal exhibitions) and photography (one published book). He has published a few fictitious novels which are based on accurate historical facts. He is an avid skier who won the regional university championship in 1948, and a strong swimmer (1/2 km at sea). He is a veteran car lover and collector of vintage cars. He has taken part in many veteran cars races, and has organized five "Microsurgical 500 Mile" races.

At the Seventh International Congress of the IFSSH in Vancouver, B.C., Canada in 1998, Professor Giorgio Brunelli was honoured with the title: "Pioneer of Hand Surgery"

DONAL M. BROOKS 1917-2004

MRCS and FRCS(Eng); BA Dublin; MB BCh BAO; MA; FRCSI; LRCP

Donal Brooks was born in Dublin, Ireland, on 10 April 1917. He was educated at Repton School, Derbyshire. Poliomyelitis contracted at the age of eight, brought him under the care and spell of Sir Robert Jones in Liverpool. Thereafter his future career was never in doubt. He qualified in medicine at Trinity College, Dublin in 1942, and did his early orthopaedic training with Arthur Chance at Dr. Steevens' Hospital in Dublin. In 1948, he joined Herbert J. Seddon at the Wingfield-Morris Orthopaedic Hospital in Oxford, UK where he specialised in orthopaedic surgery.

During the Second World War, the Medical Research Council set up five Peripheral Nerve Injury Centres throughout Britain under the coordination of Seddon at Oxford. The vast clinical data provided gave his research team the possibility to evolve a positive conservative and operative approach to these injuries. The prevalence of anterior poliomyelitis and the sequelae of nerve injuries developed in Donal a lifelong and absorbing interest in reconstructive surgery of the upper limb.

Donal Brooks moved to London with Sir Herbert Seddon when the latter became Professor at the Royal National Orthopaedic Hospital. In 1957 he was appointed consultant orthopaedic surgeon to Barnet General Hospital. He was also on the staff of the University College Hospital and King Edward VII Hospital for Officers, as well as the Chailey Heritage and St Luke's Hospital for the Clergy. In addition he was Civilian Consultant in Hand Surgery to the Royal Navy and to the Royal Air Force. Brooks had an extensive private practice in Harley Street, London, which included three Prime Ministers and three Kings! He travelled extensively in the Middle East, Europe and further afield, as a honoured guest lecturer and traveling professor.

In 1983, he was elected Honorary Member of the American Society for Surgery of the Hand and delivered the Founder Lecture in Anaheim. In 1979, he was greatly privileged to be the Robert Jones Memorial Lecturer at the Royal College of Surgeons England, having been a patient of Robert Jones some fifty years previously. He served on the Court of Examiners of the Royal College of Surgeons of England and becoming its chairman. Brooks was member of the British Orthopaedic Association (BOA) and served on its editorial board.

Donal Brooks was a member of many international Hand Societies. He has published extensively on poliomyelitis and hand surgery and has contributed to several textbooks of surgery and particularly to "Peripheral Nerve Injuries", a British Medical Research Council publication edited by Sir Herbert Seddon, which summarized the experience of the war years. His other interests included music, ballet and particularly vintage cars! Donal Brooks was married to Stephanie Mackworth Praed (Seddon's secretary!), and they had three sons and three daughters.

He will be best remembered for his clinical teaching sessions carried out with good humour and enjoyed by everyone, and especially by his patients with whom he had a remarkable rapport.

At the Seventh International Congress of the IFSSH in Vancouver, B.C., Canada in 1998, Donal M. Brooks was honoured "Pioneer of Hand Surgery"

IFSSH

Scientific Committee on Carpal Instability

Part I: Definition and Investigations

Chair: Max Haerle (Germany)

Committee: Abhijeet Wahegaonkar (India), Marc Garcia-Elias (Spain), Gregory Bain (Australia), Riccardo Luchetti (Italy)

Introduction

The wrist is a load bearing articulation able to resist both compressive and torsional loads without yielding. For this to happen, there is a need for: 1) a coordinated action of the muscles crossing the joint, 2) smooth and normally tilted joint articular surfaces, and 3) a system of interdependent ligaments. In the presence of muscle imbalance, ligament insufficiency and/or bone deformity several patterns of wrist instability may appear. From this point of view, carpal instability may be described as the inability of the wrist to maintain a normal balance between the articulating surfaces under physiologic loads (dyskinetics) and/or movements (dyskinematics). When the wrist is not able to keep normal articular alignment when subjected to physiologic deforming forces, the wrist is said to be unstable.

Not long ago, carpal instabilities were only identified if the patient was referred to a knowledgeable wrist specialist. Nowadays, the diagnosis is often established in the emergency rooms of our hospitals. Certainly, the general understanding of these complex injuries has improved. Such an increased awareness,

however, has not been followed by an increase in the quality of the results obtained. Indeed, the literature concerning the management of carpal instabilities still is rich in misconception justifying surgical techniques that have not yet proved the test of time. We are certainly improving, but we are not definitively there yet.

The natural history of carpal instabilities is still unclear. It is not unusual to find authors defending the notion that all ligament injuries will sooner or later evolve hopelessly into a symptomatic osteoarthritis. Now we know that ligament ruptures do not always generate instability, nor is all wrist osteoarthritis derived from an unstable joint. Furthermore, some malaligned, theoretically unstable wrists are well tolerated, if not completely asymptomatic. E.g. those produced by malunited fractures of the lower end of the radius or the dynamic midcarpal instability in patients with hyperlaxity of their joints. Others, such as scapho-lunate dissociation, may rapidly lead to degenerative arthritis and require early detection and treatment.

Classification

Carpal instability is difficult to classify. Many diverse clinical conditions may result in an unstable wrist for which different classifications have been suggested. Carpal instability has been classified based on seven parameters:

1. Aetiology (congenital, developmental, post-traumatic),
2. Location of the initial injury (extrinsic, intrinsic ligament, bone),
3. Characteristics of the original injury (partial vs. total; repairable vs non-repairable, reducible vs. non-reducible),
4. Constancy of the radiological findings (pre-dynamic, dynamic, static),
5. Location of the predominant dysfunction (dissociative scapholunate, dissociative luno-triquetral, non-dissociative radiocarpal, non-dissociative midcarpal),
6. Chronicity of the dysfunction (acute, sub-acute, chronic),

7. Direction of the resultant malalignment (DISI, VISI, ulnar translocation).

Unfortunately, none of these provide a comprehensive enough classification which is able to be used to decide a treatment. Algorithms of treatment based on a combination of the seven parameters have also been proposed. The ideal algorithm must include all possible forms of carpal instability, and be simple enough as to be easily remembered.

Although imperfect, the analytical scheme proposed by Larsen and Associates in 1995 (Table 1) and the recently revised algorithm of treatment originally proposed by Garcia-Elias, Lluch and Stanley (2006) fulfil these criteria. Needless to say, there is a need for further refinement in this regards.

Table 1: A summary of classification types for carpal instability is presented below in a tabular form⁵

Category I Chronicity	Category II Constancy	Category III Etiology	Category IV Location	Category V Direction	Category VI Pattern
Acute < 1 week (Maximum primary healing potential)	Predynamic Dynamic Static reducible	Congenital Traumatic Inflammatory	Radiocarpal Proximal Intercarpal Midcarpal	VISI rotation DISI rotation Ulnar translation	Carpal instability dissociative (CID)
Subacute 1-6 wks (some healing potential)	Static irreducible	Neoplastic Iatrogenic Miscellaneous	Distal intercarpal Carpometacarpal Specific bones	Carpal instability Dorsal translation Other	Carpal instability non-dissociative (CIND)
Chronic >6 wks (little healing potential)					Carpal instability complex (CIC)
					Carpal instability adaptive (CIA)

SCAPHOLUNATE DISSOCIATION

Introduction

Injuries to the scapholunate ligament and the secondary restraints may lead to different degrees of scapholunate instability. Dependently this may lead to a considerable degree of wrist dysfunction, inability to work and interference with manual activities.

If left untreated, it can lead to wrist osteoarthritis. Impairment of the scapholunate interosseous ligament (SLIL) in association with injury to the extrinsic ligaments is known to lead to rotatory subluxation of the scaphoid, dorsal intercalated segment instability (DISI) and finally scapholunate advanced collapse (SLAC).⁷

Anatomy

The SL ligament consists of three distinct structures: the two SL ligaments (palmar and dorsal) and the proximal fibrocartilaginous membrane.⁸

The dorsal SL ligament is located in the depth of the dorsal capsule and connects the dorsal aspects of the scaphoid and lunate bones. It is formed by thick and stout collection of fibers, slightly obliquely oriented, with a key role in SL stability. The dorsal component is a true ligament with transversely oriented collagen fibers, and is a primary restraint not only to distraction, but also to torsional and translational moments.

The palmar SL ligament, although considerably thinner, has important contributions to rotational stability of the SL joint. The proximal membranous portion of the SLIL is histologically a fibrocartilaginous structure, and in isolation, contributes little to the restraint of the normal motion of the SL joint⁹. However, recent publications have also highlighted the major role of the secondary restraints, the dorsal intercarpal and radiocarpal ligaments in maintaining scapholunate stability.

In a study by Elsaidi et al¹⁰, the authors found that after sequential sectioning of volar ligaments and the scapholunate interosseous ligament, no scapholunate

diastasis or excessive scaphoid flexion occurred. After dividing the dorsal intercarpal ligament, scapholunate instability occurred without carpal collapse. With detaching the dorsal radiocarpal ligament from the lunate, a dorsal intercalated scapholunate instability deformity ensued.

More recently, van Overstraeten et al¹¹ described an attachment between the dorsal wrist capsule, the dorsal part of the scapholunate interosseous ligament (SLIOL) and the dorsal intercarpal ligament (DIC) which they termed the Dorsal Capsulo-ligamentous Scapholunate Septum (DCSS). (Figure 1)

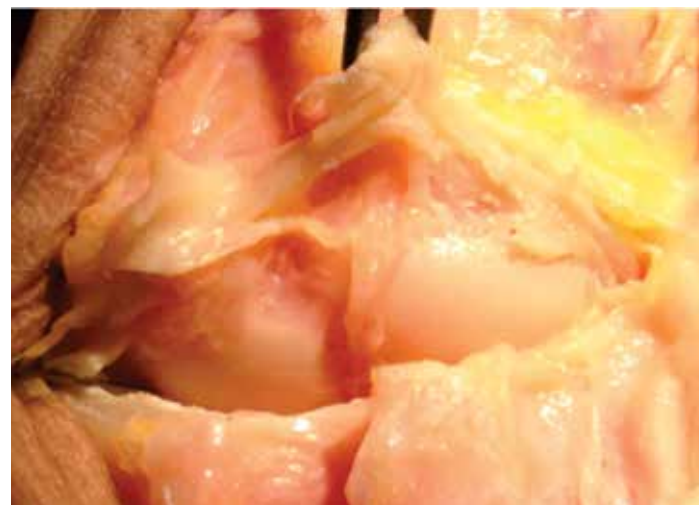


Figure 1: The Dorsal Capsulo-ligamentous Scapholunate Septum (DCSS) is thought to be an important stabilizer of the SL joint, which may have therapeutic and prognostic implications.

There are other factors that also determine carpal kinematics. For example ligamentous laxity and carpal morphology affect carpal kinematics.¹² The lunate morphology determines the kinematics of the normal scaphoid, and the abnormal scaphoid.¹³⁻¹⁵ Viegas et al⁴¹ classified lunate morphology as either type 1 or 2, according to the number of facets (one or two, respectively) present on the midcarpal surface of the bone. Lunate type is associated with carpal pathology. Type 1 lunate wrists have a higher incidence of Dorsal Intercalated Segment Instability deformity in the setting of scaphoid non union¹⁴, and type 2

lunate wrists are associated with proximal hamate⁴¹ and scapho-trapezial-trapezoidal joint⁴² degeneration. Lunate morphology is associated with differences in the ligamentous anatomy⁴³ and the kinematics of the carpus, particularly in the central carpal column (radius-lunate-capitate)^{13,15} (Figure 2)⁴⁷.

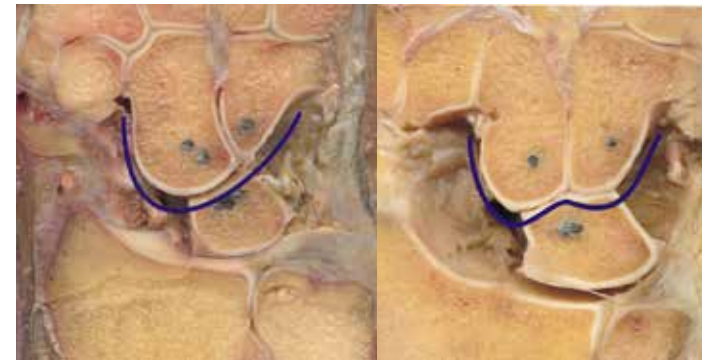


Figure 2: Type 1 and type 2 lunate shown in these cadaveric wrists. The type 1 has a single distal facet to articulate with the capitate. The type 2 lunate has 2 distal facets that tend to lock the midcarpal joint. (Used with permission from Fogg)⁴⁷

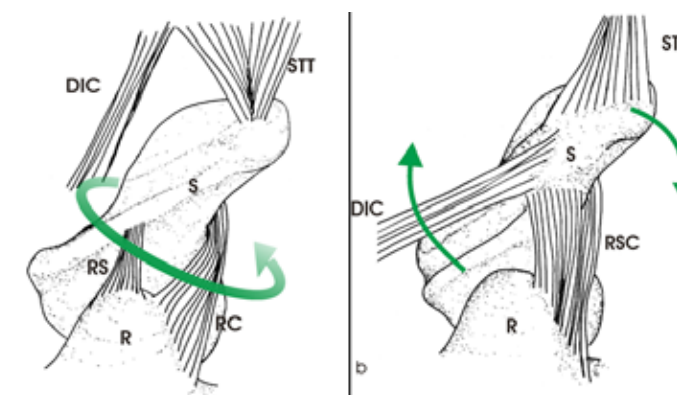


Figure 3: Scaphoid rotation and flexion

There are anatomic differences in the ligament attachments of the scaphoid. The ligament attachments may predispose to rotation or flexion of the scaphoid. (Figure 3 - used with permission from Quentin Fogg)⁴⁷

The majority of wrist flexion and extension motion occurs at the three radio-carpal articulations of a type 2 lunate wrist, with the midcarpal articulations being comparatively restricted. In contrast, type 1 lunate

wrists have greater motion at the luno-capitate joint and less at the radio-lunate joint during the same wrist movement¹⁵ (Figure 4).

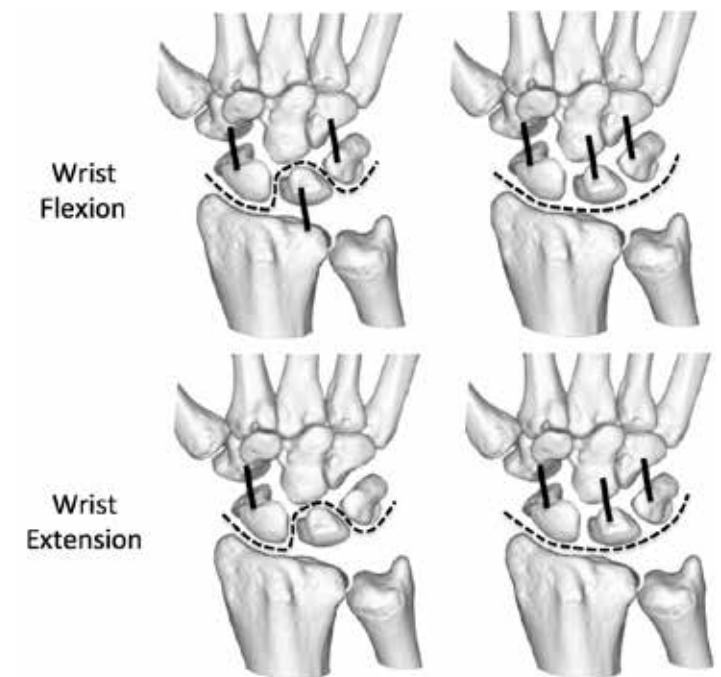


Figure 4: The wrist type determines the dominant and restricted articulations. In the type 1 wrists, the dominant articulation alternates between the radiocarpal and midcarpal joints. In type 2 wrists, all the midcarpal articulations are restricted and all the radiocarpal articulations are dominant. (In plane motion with wrist flexion (15°) and extension (15°). Dashed line = Dominant articulation (≥50%). Solid bar = restricted articulation (<4°). (Copyright G.I. Bain. Used with permission).

Pathoanatomy

The mechanism of injury is usually a fall onto an outstretched hand. With the wrist in extension there is a risk of sustaining an injury to the scapholunate ligament, or alternatively a fracture of the scaphoid or distal radius can occur. The scapholunate ligament injury can be part of a perilunate injury⁵⁸, or part of a carpal dislocation (Figure 5).

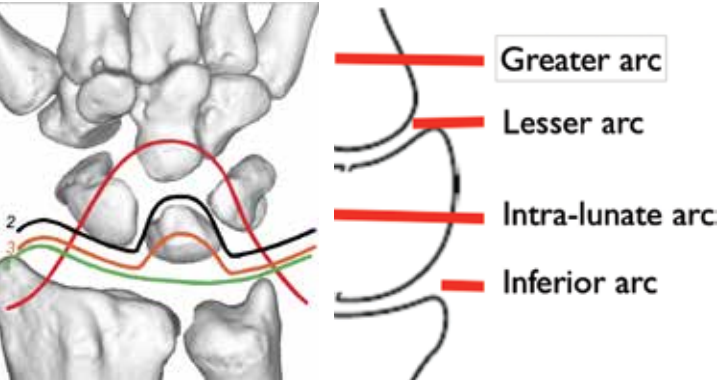


Figure 5: Dislocation classification, the spectrum of radiocarpal dislocations that can occur. These include the greater arc (1), lesser arc (2), intra-lunate arc (3) and the inferior arc (4). ⁵⁷

History and Physical Examination

The history reported by the patient with scapholunate dissociation usually includes weakness and pain with strenuous activities.⁷ Physical findings usually include swelling in the radial snuffbox or tenderness over the scapholunate interval just distal to Lister’s tubercle, pain at the extremes of wrist extension and especially radial deviation, and a positive ballottement test (dorsal volar stress manipulation of the scapholunate interval). Subluxation of the proximal pole of the scaphoid associated with a clunk during dynamic wrist loading (the Watson scaphoid shift test) frequently is present on dynamic testing.¹⁶

The examiner’s thumb applies pressure to the scaphoid tubercle as the patient’s wrist is brought from a position of ulnar deviation and slight extension to radial deviation and slight flexion. The scaphoid will normally flex and pronate during this manoeuvre, but in scaphoid instability the manoeuvre will be painful, and thumb pressure will force the proximal scaphoid from the scaphoid fossa onto the dorsal articular lip of the radius. Relief of thumb pressure allows the scaphoid proximal pole to spontaneously reduce, often with an audible or palpable “clunk.” Patients with an appropriate history and a positive scaphoid shift test should be considered as having a suspected SLIL disruption and should be evaluated further with appropriate imaging or arthroscopy.

Imaging

Assessment of the unstable wrist includes plain radiology in all cases, and advanced imaging is often required to determine staging and as part of pre-operative planning.

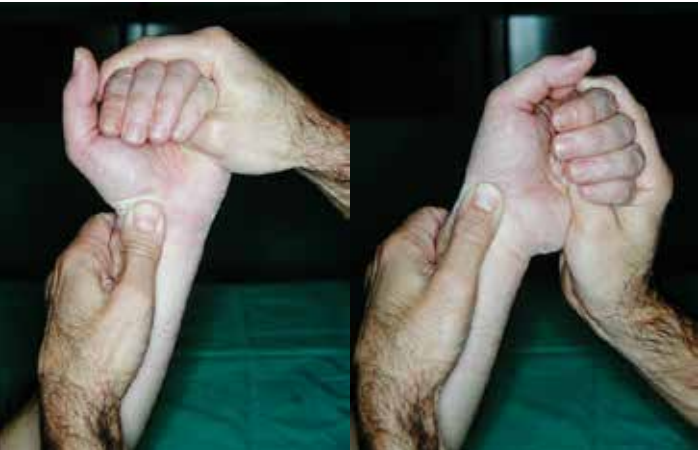


Figure 6: Watsons test: The examiner’s thumb applies pressure to the scaphoid tubercle as the patient’s wrist is brought from a position of ulnar deviation and slight extension to radial deviation and slight flexion. Assess for pain and click or clunk, due to reduction of dorsal scaphoid subluxation.

Plain Radiographs

A complete radiographic assessment with six views of the wrist (postero-anterior, lateral, radial deviation, ulnar deviation, flexion, and extension) is performed. In a patient with scapholunate dissociation, standard PA view (neutral radioulnar deviation) shows an increased scapholunate gap (≥ 3 mm compared with the opposite wrist), and the cortical ring sign of the flexed scaphoid. Lateral radiographs best show scaphoid flexion and lunate extension relative to the radius.

SL dissociation should be suspected if the scapholunate angle is greater than the normal 45° to 60° (DISI pattern) (Figure 7). Plain radiographs can be used to identify associated injuries, including the degeneration, which usually begins at the radial styloid, and later can involve the midcarpal joint (Figure 8).

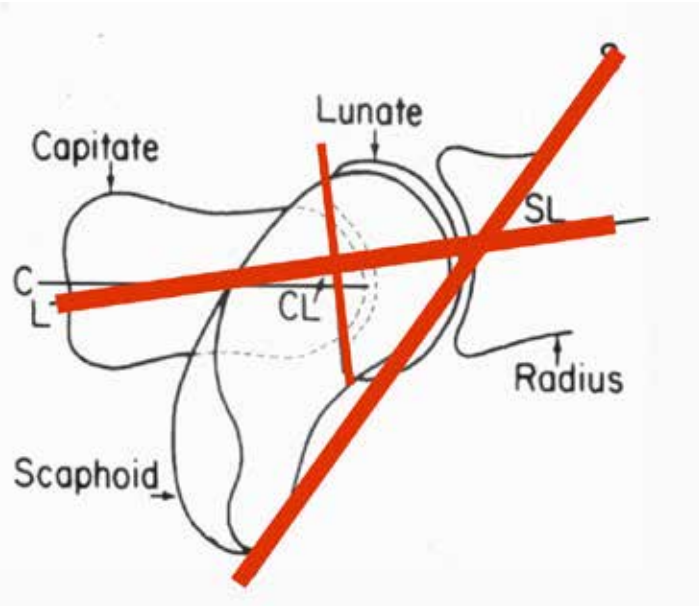


Figure 7: SLA The scapholunate angle: Identify the volar and dorsal distal cusps of the lunate. Draw a line joining these 2 points, which is the alignment of the lunate. The scapholunate angle is the angle between a line drawn perpendicular to the alignment of the lunate and the line along the volar aspect of the scaphoid. Normal is $30^\circ - 60^\circ$. Mean is 47° .



Figure 8: The plain radiographs demonstrate the natural progression of SLAC wrist with degeneration at the radial styloid, then the midcarpal joint.

Cineradiography

Even in static SLD, in which the diagnosis can be made on standard radiographs, obtaining further information using cineradiography is useful. Cineradiography shows not only abnormal movement between the scaphoid and lunate, but also substantial changes in the movement of the midcarpal joint. The hamate-triquetrum relationship normally changes from full engagement in ulnar deviation to complete disengagement in radial deviation; in SLD patients with DISI, this joint remains permanently engaged.

Arthrogram

Contrast is sequentially injected in the midcarpal and radiocarpal joints and scans obtained after each injection. These may be useful in further defining partial tears of the scapholunate ligaments, and in discovering other local problems, such as osteochondral defects or capsular ligament ruptures.¹⁷ When interpreting these scans, care must be taken not to confuse degenerative perforations, or anatomic variants of the scapholunate membrane with true ligament ruptures (Figure 9) ^{41, 54}. However, there are several limitations to arthrography, and its use has diminished substantially in favor of arthroscopy.

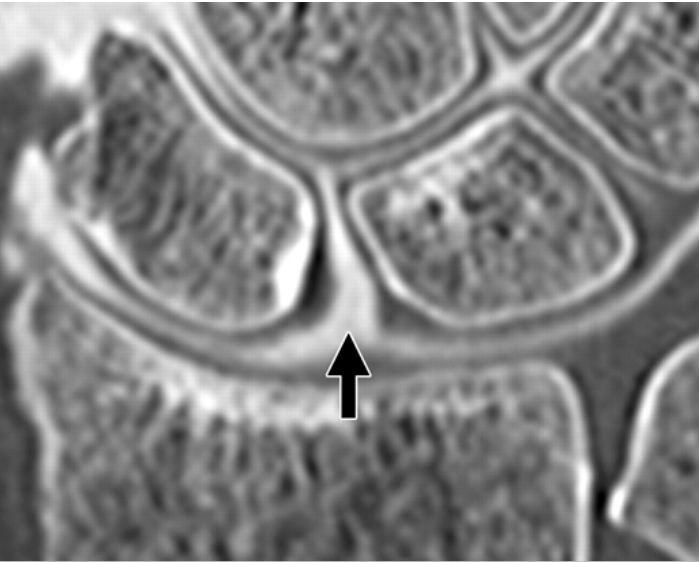


Figure 9: CT arthrogram of wrist with contrast within the SL interval.

MRI

MRI provides an assessment of the scapholunate ligament integrity, identification of diastasis and chondral changes. The resolution of the scan can make assessment of partial or complete tears unreliable, but improved resolution is certainly much better than previously.^{18,19} With the MRI the ligament can be assessed, and also the degeneration over the radial styloid (Figure 10).

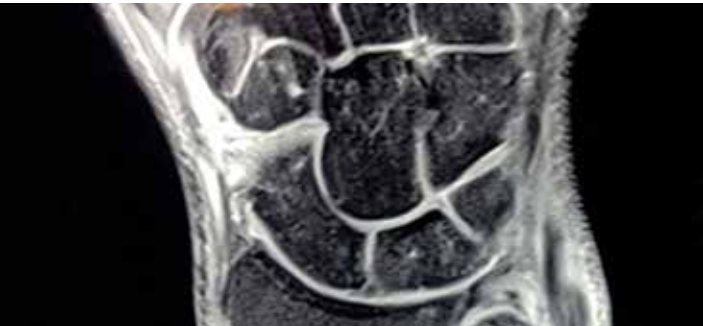


Figure10: MRI of the wrist, demonstrating the SL ligament, and adjacent carpus.

Arthroscopy

Wrist arthroscopy is regarded by many authors as the gold standard technique in the diagnosis of intracarpal derangements.¹⁸⁻²³ Three-compartment arthrography will identify perforations of the intercarpal ligaments, but it does not provide accurate localization of the tears or the extent of instability. Arthroscopy has the advantage of direct visualization of the ligaments (Figure 11), and is the most accurate technique for describing the degree of injury of the interosseous ligament, the cartilage, to distinguish fresh from chronic lesions and to analyse concomitant injuries to other structures.²⁴



Figure 11: Normal scapholunate ligament scope (a) Normal scapholunate ligament in the radiocarpal joint, with the ligament of Testut in the background. (b) The probe can be used to palpate the ligament and ensure a concealed tear is not missed.

The state of the ligament, the extent of the ligament injury, and whether it is a repairable ligament stump can be assessed directly. Associated haemorrhage, synovitis, chondral damage, and degenerative changes (e.g. radial styloid degenerative osteoarthritis) can also be visualized.

When infiltration into the midcarpal joint is being performed, a leakage of saline solution through the radiocarpal portals indicates that there must be a tear of the lunotriquetral ligament or scapholunate ligament. This is the same concept as that seen with an arthrogram where the midcarpal joint is injected and a leakage of contrast is seen in the radiocarpal joint on follow-up radiographs.²⁴

From the midcarpal joint, the degree of laxity between the scapholunate interval can be assessed. Geissler et al. described a classification for assessment of scapholunate instability. The functional significance of the ligament injury can be assessed as well – that is, the presence of a tear with or without associated significant instability (as identified in the midcarpal joint). Under the same anaesthetic, a fluoroscopic assessment of the wrist can be performed. If this is performed before draping, then the opposite wrist can be used for comparison. This examination should include placing the wrist in a neutral position, moving to full ulnar deviation, applying an axial load, and also applying traction across the wrist to determine whether there is abnormal distal translation of the scaphoid.²⁴

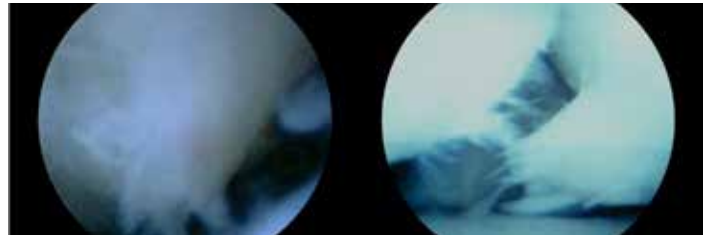


Figure 12: Scapholunate ligament tear (a) Tear of the ligament seen from the radiocarpal joint. (b) Diastasis of the scapholunate interval interval, when the Watson's test is performed under arthroscopic vision²⁴.

The scapholunate instability test of Watson et al. can be performed under fluoroscopy or arthroscopic vision (or both) (Figure 12) ²⁴. Abnormal widening of the scapholunate interval and subluxation or dislocation of the scaphoid over the dorsal rim of the distal radius can be identified.

Lunotriquetral instability can also be assessed by use of the same arthroscopic assessment techniques and specific provocation tests. Pressure is placed directly onto the pisiform and on the dorsal aspect of the lunate. By squeezing the lunate volarly and the triquetrum dorsally, lunotriquetral instability is identified.²⁴ The wrist is taken through radial and ulnar deviation with direct visualization of the lunotriquetral articulation.

Arthroscopic Classification

Because arthroscopy of the wrist is one of the most accurate means of evaluation of scapholunate instability, the classifications deduced from these findings are widely used. Geissler has proposed a method of quantifying the degree of interosseous ligament injury (Table 2), by probe placement into the scapholunate interval from the radiocarpal and midcarpal joint on wrist arthroscopy. (Figure 13). If the scope can be advanced from the radiocarpal to the midcarpal joint, it is classified as a grade 4 injury (Figure 14).

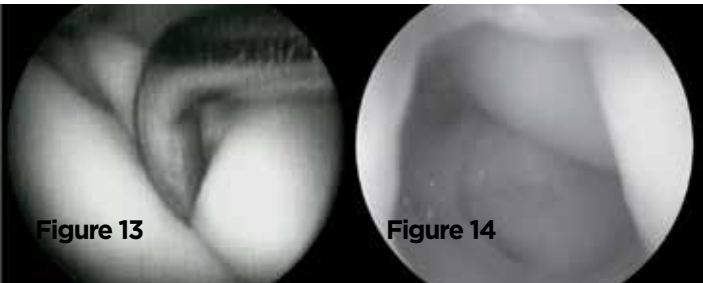


Figure 13: Probe in the scapholunate interval in the midcarpal joint. It is normal for the probe to not be able to be admitted into the interval.

Figure 14: Grade 4 tear, with the capitate seen in the interval between the scaphoid (left) and lunate (right).

Grade I
Attenuation/haemorrhage of SLIL (viewed from radiocarpal space). No midcarpal malalignment
Grade II
Attenuation/haemorrhage of SLIL (viewed from radiocarpal space) AND step off / incongruity of carpal alignment. Slight gap between carpals (less than width of probe)
Grade III
Step off / incongruity of carpal alignment (viewed from both radiocarpal and midcarpal spaces)
Grade IV
Step off / incongruity of carpal alignment (viewed from both radiocarpal and midcarpal spaces), gross instability, AND 2.7- mm arthroscope can pass through the gap between the scaphoid and lunate (positive “drive-through sign”)

Recently, the European Wrist Arthroscopy Society (EWAS) classification for SL dissociation was introduced. This is a more comprehensive classification that includes the site of the scapholunate ligament attenuation or tear.²⁶

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Letter to Colleagues

Dear Colleague:

As you know, congenital hand and upper limb malformations (CHULM) are complex conditions that profoundly influence patients' health-related quality of life. However, there is scarce information regarding outcomes during the follow-up of CHULM patients.

Uncertainty regarding treatment outcomes coupled with unsustainable growth in healthcare expenditure has driven interest in the development of standardised health outcome measures for comparing the effects of treatment across populations and for assessing quality of care. Therefore, global comparisons are essential for patient safety and improvements in the quality of care since they set the stage for more rapid learning across institutions.

ICHOM (International Consortium for Health Outcomes Measurement – www.ichom.org) is a nonprofit organisation, working with healthcare professionals, registry leaders and patient representatives from around the world to define a Standard Set of outcome measures that matter most to patients, driving the adoption and reporting of these Standard Sets worldwide.

An international working group of plastic and orthopaedic surgeons, hand and occupational therapists, genetic and outcomes researchers was assembled to review existing literature and practices. In a series of teleconferences, a modified Delphi process was used to reach consensus on what outcomes matter most to patients with CHULM.

Patient opinions and interests were obtained during patient advisory groups.

Your input as an expert in the field of hand surgery is essential for us during this stage of the Standard Set development. We would appreciate if you could provide us with your feedback by completing the survey in the link below.

If you have any questions or would like further information on this work, please do not hesitate to contact the project team (a.delatorre@ichom.org).

Survey link: https://hbs.qualtrics.com/jfe/form/SV_1TYIFdxgz8QSfb

Many thanks,

Alethse De la Torre, Jason Arora, Monique Ardon, Christianne Van Nieuwenhoven and Branavan Sivakumar

On behalf of the ICHOM Congenital Hand and Upper Limb Malformations Working Group



Visit to Komfo Anokye Teaching Hospital

Rajani Sharma-Abbott was sponsored by IFSHT with an IFSHT-IFSSH Voluntary Teaching Grant, to travel to Komfo Anokye Teaching Hospital (KATH) in Kumasi, Ghana in August 2016. She spent five days at the hospital, teaching and training the local physical therapists and occupational therapy students in the assessment and treatment of hand therapy patients.



KATH is a 1200-bed hospital with multiple specialties and it receives patients from all over the northern region of Ghana. It is a trauma center and has a large

orthopedic and plastic surgery department. The physiotherapy department is a self-standing clinic on the hospital grounds with a busy outpatient gym that treats patients from all spans of life. It is moderately staffed with PTs who provide outpatient and inpatient care. The big rehab gym is equipped with basic therapy equipment. The project was established two years ago by Dr Don Lalonde to develop hand surgery and therapy specialty in KATH. Since its inception, many hand therapy volunteers have travelled to KATH to develop a sustainable hand therapy program. Two KATH therapists are dedicated to UE caseload and train with the volunteers in a one room clinic with a desk, chair and a mat. Supplies and equipment related to hand therapy is scarce and dependent on donations. Knowledge of local therapists in UE anatomy, evaluation and treatment is in its infancy but the enthusiasm of therapists to learn is great. The type of case load varies, mostly complex trauma patients in

later stages of healing presenting with severe stiffness, contractures and chronic pain, children with birth defects, brachial plexus and other peripheral nerve injuries. Chronic wound problems and infection are common.



Rajani's report of her visit to KATH:

My time in KATH was spent in trauma rounds in the morning, where surgeons and residents presented cases and discussed possible treatments including therapy management. From the second day, I brought local therapists and students to trauma rounds and provided input on cases as necessary, mostly in positioning and management to prevent unnecessary stiffness. The surgeon got to know the local therapists personally during this time. Robert Sowa, a local PT, emailed me to say that doctors are referring patients to him for hand therapy now.



The rest of my visit was spent providing direct treatment to hand therapy patients. Robert and the students presented each case and we worked together to identify anatomy, pathology, course of treatment and use of therapeutic activities. I focused on education about pain management, empathy, importance of the home exercise program and orthosis management for chronic stiffness, and had the opportunity to review some patients who came back later in the week for

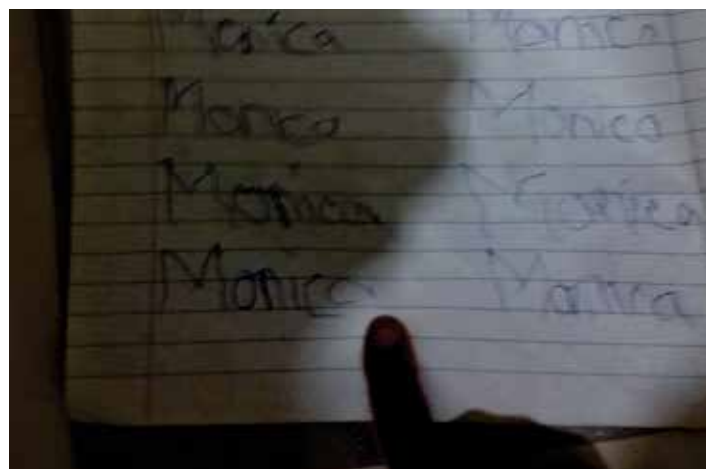
follow up. The week concluded with my presentation on the 'Evidence based use of modalities in rehabilitation' which was received well by an audience of over 10 therapists.



Case study: A nine-year-old girl, Monica, presented with severe infection after distal radius fracture, and amputated digits at PIP/DIP level. She had minimal function of the nerves and walked around with her hand covered with sleeves of her shirt (she was too embarrassed to show her hand to anyone). She was brought in to see me to fabricate an orthosis to cover her hand and to open her 1st web space.



The only function she had of her hand was slight adduction of her thumb to index. This became a learning/teaching opportunity for me and Robert and the OT students: do we support her desire to cover her hand or do we help the patient and her mom to accept what is? If we widen her 1st web space, would she still be able to complete her lateral pinch motion, or lose what function is left?



Through empathy, talking with Monica's mom and listening to Monica about her feelings of her hand, we figured out that writing with that hand is what she misses the most. We spent the session trying writing with various adaptations/techniques and gave her homework to write 1 page every day with that hand and follow up with us later in the week. In her follow up, she ran up to us, gave a hug and produced 3 pages of writing. We all were hugging with tears of happiness. We told her that she had a beautiful hand and that it can do many things if she puts her mind to it. We decided that she won't need anything to cover her hand. The OT students (second group to ever graduate as OTs in Ghana) told me that this was the first time during their clinical rotation where they were able to observe the clinical application of the academic theory they had learnt at University.

In addition, I was able to teach and train Robert and the OT students in use of Plaster of Paris to fabricate orthoses of various types, use of dynamometer and goniometer evaluation tools, and problem solve complex cases. I also learned and shared the importance of recognizing limitations posed by severity of specific diagnoses, and to use empathy as a powerful therapeutic tool. The highlight of my trip was working with Robert Sowa and the eager OT students, giving them OT perspective on all the cases and to let them use occupation as a therapeutic tool.

The program that started 2 years ago to bring hand

therapy concepts in KATH hospital is doing well, attracting volunteers throughout the year. There is much to be done in terms of training, equipment and supporting the department to better treat hand therapy patients. It is my intention that I will try to network and help Robert Sowa, the PT that I worked with, to attend conferences and perhaps shadow in a hand



therapy clinic for a few weeks here in the US. I am very grateful to IFSHT for awarding me the grant to assist with my trip to Ghana to share my knowledge and skills of hand therapy. Like always, I learned so much and felt privileged to be doing international hand therapy trips. IFSHT is pleased to report that Robert Sowa has recently applied to join IFSHT as a corresponding member.

About the IFSHT-IFSSH voluntary teaching grant: IFSHT supports voluntary teaching projects in countries where hand therapy is developing. Examples of other past projects that have received grant support from IFSHT include a splinting course in the Czech Republic, a hand therapy teaching project in Cameroon and a paediatric hand therapy course in Moldova. Grants of up to \$US1000 per project are available. The grant application can be found online on the IFSHT website at <http://www.ifsht.org/page/international-teaching-grants-0>. Applicants are advised to submit grant applications a minimum of 4-6 months in advance.

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How long can surgery for the pediatric trigger thumb be delayed?



Goo Hyun Baek
Professor: Department of Orthopaedic Surgery Seoul National University Collage of Medical Saoul Korea

INTRODUCTION

Pediatric trigger thumb is a stenosing condition of the flexor pollicis longus (FPL) tendon under the A1 pulley and exhibits triggering, flexion deformity of the thumb interphalangeal (IP) joint, or snapping movement of the thumb. Patients most commonly presented at the age of 2 years (Baek et al., 2008, Dinham and Meggitt, 1974, Marek et al., 2011, Slakey and Hennrikus, 1996, Tan et al., 2002), and approximately 25-33% of patients showed bilateral involvement (Baek et al., 2008, Dinham and Meggitt, 1974, Marek et al., 2011).

There have been controversies whether it is a congenital or acquired condition. However, several studies of neonatal survey supported that pediatric trigger thumb is an acquired condition. Tan et al. (2002) reported that the onset of trigger thumb was ranged from 3 months to 10.2 years. Currently, it is widely accepted as an acquired condition, and the diagnosis has been changed from “congenital trigger thumb” into “pediatric trigger thumb”. There were several reports which described natural history of the pediatric trigger thumb. Baek and Lee (2011) reported 76% of spontaneous resolution rate among the patients with a minimum of five years follow-up. Considering the natural history of this condition, most patients do not need surgical treatment.

TIMING OF SURGERY

Chalise et al. (2013) reported that trying conservative methods to get a higher chance of recovery is reasonable before the elective surgery because the surgery was not urgent and postponing surgery did not interfere with the result. Skov et al. (1990) reported that the risk of residual flexion deformity

was no higher following operations conducted in patients who were more than three years old. Han et al. (2010) reported that the surgical treatment with A1 pulley release for over 5 years of age resulted in successful resolution of trigger thumb and satisfactory clinical outcome in all patients.

My current surgical indications for the pediatric trigger thumbs include ‘no improvement of extension lag for more than 5 years of observation’, and ‘locked pediatric trigger thumbs without any improvement of extension lag for more than 3 years of observation’. Because all the patients with pediatric trigger thumb were initially recommended to be waited for a long time in my clinic, patients’ age at the time of surgery should be older than any other clinics. During last 12 years, I had operated 15 thumbs in 15 patients whose average age at the time of surgery was 7 years and 1 month. Nine of them showed no improvement of extension lag for more than 5 years of observation, and six had locked pediatric trigger thumbs without any improvement of extension lag for more than 3 years of observation. Surgical outcome was

excellent in all patients without any residual deformity (Table 1). Then, how long can surgery for the pediatric trigger thumb be delayed? The outcome was excellent if the operation for pediatric trigger thumb is done before teenage (Han et al, 2010; Baek and Lee, 2011). If it is performed after teenage, I believe the surgical outcome will be excellent as well.

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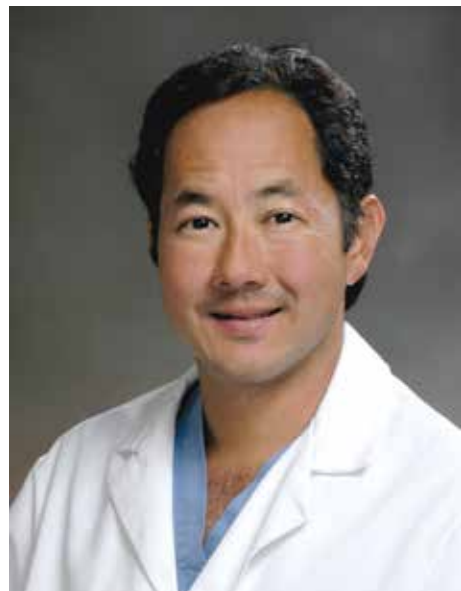
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Patient Number	Sex	Affected Side	Age at Detection (Year ⁺ Month)	Extension Lag at First Visit	Age at Surgery (Year ⁺ Month)	Duration of Resolution	Duration of Follow Up (Year ⁺ Month)
1*	F	Lt	3 ⁺ 1	40°	6 ⁺ 1	2 weeks	3
2	F	Rt	1 ⁺ 3	20°	6 ⁺ 6	2 weeks	5 ⁺ 4
3	M	Rt	1 ⁺ 11	30°	12 ⁺ 2	2.5 weeks	11 ⁺ 5
4	M	Rt	0 ⁺ 10	15°	9 ⁺ 6	1.5 weeks	8 ⁺ 8
5	M	Lt	1 ⁺ 3	45°	6 ⁺ 2	2 weeks	6 ⁺ 1
6*	F	Lt	1 ⁺ 3	20°	6 ⁺ 6	2 weeks	3 ⁺ 11
7	F	Rt	0 ⁺ 11	45°	6 ⁺ 10	1 week	7 ⁺ 1
8	F	Lt	2 ⁺ 1	56°	7 ⁺ 3	2 weeks	7 ⁺ 4
9*	F	Rt	4 ⁺ 7	40°	8	2 weeks	7 ⁺ 3
10*	F	Lt	2 ⁺ 5	56°	7 ⁺ 3	2 weeks	2 ⁺ 8
11	F	Lt	2	30°	7 ⁺ 6	3 weeks	6 ⁺ 10
12	M	Lt	1 ⁺ 4	57°	6 ⁺ 6	2 weeks	3
13*	M	Rt	2 ⁺ 6	25°	5 ⁺ 9	1 week	6 ⁺ 6
14	F	Rt	1	45°	10 ⁺ 5	1 week	10 ⁺ 6
15*	F	Rt	3	47°	6 ⁺ 6	2 weeks	2 ⁺ 11
Average (Range)			23.5 months (0+10 to 4+7)	38° (15° to 57°)	7 ⁺ 1 (5 ⁺ 9 to 12 ⁺ 2)	1.9 (1 to 2.5)	6 ⁺ 10 (2+8 to 11+5)



Pearls of Wisdom



Scott N Oishi
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surgery and Orthopaedic Surgery UT
Southwestern Medical school
Dallas, Texas, USA

We all have mentors that we not only respect as surgical teachers, but who also taught us invaluable lessons regarding the treatment of patients. My two most important mentors were Marybeth Ezaki and Peter Carter. I would like to share important “philosophic” lessons they taught me that I use each and every day in practice, as well as, instil in my trainees.

One of the most important is the “2-4 rule”. Put simply, there are a lot of surgeries we can think of to (2) perform on a patient, but we must always make sure it is for (4) the patient. Although this seems very simplistic and basic, I always think about this when scheduling a surgery. Am I really doing something that will benefit them? Are the potential benefits of the surgery worth the inherent risks? (risk/benefit profile)

Another is “beware of the merry-go-round”. As we all start practice we are filled with wonderment and ideas on “novel” procedures to perform for a specific diagnosis. It is imperative that we review the experiences of those before us, as many times our “novel” procedure

has been tried before. In this way we avoid trying to “re-invent the wheel” and instead either modify or add to what has been done before.

Regarding the treatment of children, one of my favourite sayings is: “We love them but we can’t trust them, so put them in a cast”. What a great statement that is and how true! Frequently, we perform intricate reconstructions on children’s fingers and hands and expect them to care for it as an adult. Why put the reconstruction at risk from a child who will lick, pick, scratch, or poke at an incision or pin? It is much better to “put it away” for the required amount of time in a closed mitten cast and not have anyone look at it. You will be amazed at the decreased angst that will result from this simple practice. That being said, the cast has to look “good.” At the end of cases we are often tired and/or ready to go on to the next case and the dressing/cast is the least of our concerns. Remember, the only thing that the parents judge the surgery on is what the cast looks like! A sloppy looking cast intuitively means to them that the surgery was also “sloppy.”

“beware of the merry-go-round”

Lastly, we always have a plan “A” that we have formulated prior to entering the operating theatre. But what if plan “A” doesn’t work when you are in surgery? You need to be prepared with a plan “B” and “C” just in case. When thinking about a particular case, I always have a back-up plan in mind in case my original plan doesn’t work. As you can understand, this is very important as surgeries do not always go as planned. For trainees, it is so invaluable for them to see that their teachers are prepared to change direction in a surgery if and when it becomes necessary.



An important spin-off of this is that if a plan “A” didn’t work at the initial surgery you need to not repeat the same plan unless there was a plausible reason that the plan failed initially (i.e. infection, graft loss, etc.) If that cannot be identified then surely do not perform “A” again!

In summary, whilst we learn an incredible amount from our teachers/mentors in regards to specific techniques and diagnoses, some of the most important lessons can be learned from their general approach and philosophies. It is imperative that we are able to understand these and incorporate them into our daily practices as it surely will make us better surgeons.



CANADIAN SOCIETY FOR SURGERY OF THE HAND

Two years ago, Manus Canada was transformed into the Canadian Society for Surgery of the Hand (CSSH). The second annual meeting will take place in Winnipeg on June 20, 2017 between 5 and 9PM, preceeding the GAM Canada and CSPA meetings. The 2016 CSSH meeting was held in Ottawa. There were 20 registrants, but with over 80 attendees the meeting had to be relocated to a bigger room to provide seating for all of the CSSH enthusiasts! The program included orthopedic and plastic surgeons from across the country giving practical and clinically-driven topics.



Figure 1: Dr. Ronald Zuker speaking on free functioning gracilis transfer to the upper extremity.



Figure 2: Drs. Steven McCabe, Doug Ross and Dimitri Anastakis after completion of the program.



Figure 3: Drs. Steven McCabe and Paul Binhammer after completion of the program.

We anticipate that this year will be equally successful. Dr. Oskar Aszmann from Vienna will deliver the keynote address, "Innovative Concepts in Peripheral Nerve Reconstruction- from bench to bedside." This is an exciting timely topic with the rapid and exciting advancements in technology for addressing upper extremity amputation and the potential to further develop these programs in Canada. Here is the link to Dr. Aszmann's Ted Talk: <http://bit.ly/OskarAszmannTedTalk>.

The 2017 program has a diversity in hand and wrist surgery topics from surgeons across the country. All talks are 6 minutes in length and provide tips and pearls. Registration can be onsite or prior to the meeting and is \$20 for residents and fellows including food and beverages. We look forward to another fun and educational evening at the second annual CSSH meeting!

Also don't forget that the CSSH is the guest society at the ASSH meeting in San Francisco in September 2017. Members of the CSSH are encouraged to attend, present their work and add a bit of a Canadian flavour to the American meeting!

Heather Baltzer - University of Toronto

Paul Binhammer - University of Toronto

Don Lalonde - Dalhousie University

AMERICAN ASSOCIATION FOR HAND SURGERY

Focusing on Global Hand Care, Health and Education

Coming off of a successful Annual Meeting in Waikoloa, Hawaii, the American Association for Hand Surgery is already at work planning its 2018 Annual Meeting to be held January 10-13, 2018 at the El Conquistador in Fajardo, Puerto Rico, with the Italian Society for Surgery of the Hand as the guest organization. Under the direction of President Dr. Chris Pederson and Program Chairs Dr. Warren Hammert and Kim McVeigh, the 2018 program is already well underway. As a unique organization of both hand surgeons and hand therapists, the AAHS meeting content reflects the collaboration of both groups, and so we welcome all hand surgeons and hand therapists to join us in Puerto Rico next year. <http://meeting.handsurgery.org/>



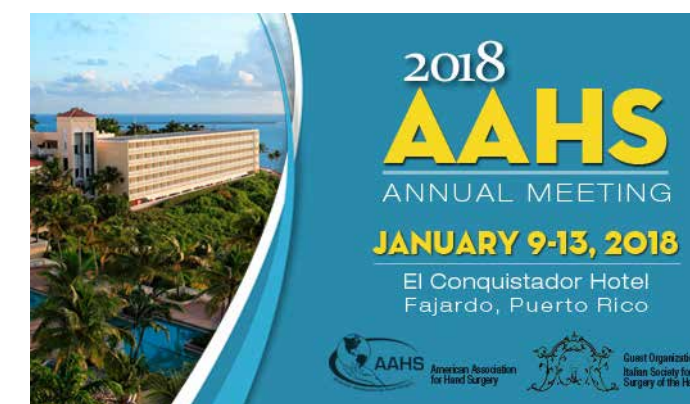
AAHS has also dedicated time over the past year to focus on its journal, HAND. Under the Editorship of Dr. Michael Neumeister, HAND was recently included in the Medline database, vastly improving online accessibility of its articles for citation. HAND is now published bi-monthly. Interested authors can visit the journal's website to learn more.

In addition to the Annual Meeting and journal, the Hand Association offers a webinar series with the aim to provide hand care education on a global scale. The Association has held 3 extremely well attended webinars in 2016, and another two are being planned for 2017. These webinars are FREE to any and all

participants. More information is available online at <http://handsurgery.org/>.

AAHS and its Hand Surgery Endowment continue to advance global hand care, health and education through various programs, including weekly lectures to orthopedic, plastic surgery and trauma residents as well as hand therapists at the Komfo Anokye Teaching Hospital in Kumasi, Ghana. This has become a successful program for all organizations involved, and the AAHS Education Committee hopes to expand its reach to other countries in the future. To supplement these efforts, HSE continues to grant the Vargas International Hand Therapy Teaching Award, a program which it has supported for over 20 years, and awarded eight volunteer scholarships to junior surgeons, fellows and therapists to travel to different locations to provide education and care in 2017. The Association and Endowment leaderships are hopeful 2017 will be an educationally impactful year and encourage anyone interested in learning more about its activity to visit <http://handsurgery.org/>.

Finally, on a sadder note, Dr. Jaiyoung Ryu, a long time contributor to international hand surgery and friend to many in IFSSH, suffered a cervical spinal cord injury while vacationing in Hawaii after attending the AAHS Annual meeting there. His injuries have left him quadriplegic, but he has been rehabilitating as bravely and energetically as all who know him would expect. For those who wish to contact him, correspondence can be sent to Dr. Ryu at 525 Middlefield Road #1081, Redwood City, CA 94063.



BRITISH SOCIETY FOR SURGERY OF THE HAND

The BSSH continues to prosper & has expanded beyond all recognition from the original incarnation when it was formed out of the Second Hand Club in May 1956. The society has over 800 members & associates & is fully integrated amongst plastic and orthopaedic hand surgeons. There are close links with the British Association of Hand Therapists (BAHT) with a joint meeting every three years.

Although hand surgery is not a separate specialty in the UK, many departments are integrating plastic & orthopaedic surgeons into a combined hand 'team' with the ability to treat patients & train Registrars across the full 'hand spectrum' in one 'centre'. This reflects the true nature of hand surgery as an 'interface' specialty and is supported by the development of the UK advanced training posts (ATPs) in hand surgery, an established hand surgery curriculum and the 'Hand Diploma'.

Once again, the series of Instructional courses in Manchester has commenced in 2017. Two programmes a year support the hand surgery curriculum and the first, on skin, soft tissue, infection & Dupuytren's Disease was well attended 3-4th February. This was preceded by a very successful revision day for the 'Hand Diploma' & 'European Board of Hand Surgery Diploma'. The second course in this series is in June (16-17th) with another excellent faculty delivering lectures on Nerve Injury, Nerve decompression, Pain & Anaesthesia. These courses continue to be very well attended, providing advanced teaching at senior trainee or consultant level, with lecturers invited from around the globe and are open to everyone.

In 2016, under the presidency of Rupert Eckersley, we held two very successful scientific meetings in London & Cardiff with the latter being attended by over 450 delegates, a record for the BSSH. Prof Grey Giddens is our president for 2017, and once again we return to the

Assembly Rooms in the historic Roman city of Bath for our Spring Meeting – April 27-28th & we visit the Scottish capital, Edinburgh for our Autumn meeting in November (9 – 10th). All are welcome.

The BSSH is one of the founding members of the IFSSH & with BAHT we are delighted to have won the opportunity to host the joint IFSSH/IFSHT congress in London, 2022. The successful bid was delivered by David Shewring (BSSH President elect) at the IFSSH meeting in Buenos Aires, despite strong competition from Belgium, Portugal & Switzerland.



Celebrating the successful BSSH bid in Buenos Aires:
(L-R) David Warwick (BSSH; incoming IFSSH Historian); David Newington (BSSH Delegate to the IFSSH); Eduardo Zancolli (2016 Congress President, Buenos Aires), David Shewring (BSSH President Elect, 2022 Bid Presenter)

London is a truly great and historic city. We are offering a superb conference venue in the heart of Westminster. London has excellent travel links and we look forward to welcoming you and delivering a spectacular meeting during the week following 25th June 2022.

Even in this 'Brexit' climate the BSSH remains totally committed to FESSH. We are looking forward to joining our European colleagues in Budapest in June and we are honoured to be the guest society of the German (DGH) hand society at their meeting in Munich in October later this year.

Indeed, we are fortunate in the foresight of our

predecessors who set up the British Journal of Hand Surgery, now the European Journal. This started by publishing papers from British authors but is now a truly international journal with a Chinese Editor-in-Chief and two European Editors in the editorial team. We have come a long way in 60 years.

David Newington - IFSSH delegate for the British Society for Surgery of the Hand

AMERICAN SOCIETY FOR SURGERY OF THE HAND

The ASSH is excited to announce three new opportunities to increase collaboration and learning among U.S. hand surgeons and the international hand surgery community.

International Visiting Professor Program

The ASSH Visiting Professor Program is designed to support veteran hand surgery educators to travel and participate in teaching activities around the world. Trips are designed around a national hand conference in the host country, in conjunction with pre- or post-conference visits to smaller teaching sites in or around the region. The program's focus is on elevating and enhancing the hand surgery specialty and developing new relationships within the global hand surgery community. The ASSH will provide a travel stipend to cover the cost of international airfare for up to six visiting professorships each calendar year. Interested hosts must submit a detailed application and commit to covering the cost for housing accommodations, meals and local ground transportation for the Visiting Professor during his or her stay. We are currently accepting host country applications for 2017 and 2018. Applications are accepted on a rolling basis until all spots are filled for each year. All IFSSH Member Societies are invited to apply. Learn more by visiting <http://bit.ly/VisitingProfessor> or by contacting the ASSH at info@assh.org.

Harold E.. Kleinert Traveling Fellowship

The goal of this award is to honor Dr.. Kleinert's legacy by supporting the education of young hand surgeons outside the United States. Promising hand surgeons, with fewer than 15 years in practice are encouraged to apply for a \$7,500 USD travel award to visit one or more hand surgery centers around the world.

The winner will be selected later this year and his or her travels will take place in 2018. This award is administered by the ASSH and funded through the American Foundation for Surgery of the Hand. Learn more about eligibility and how to apply at AFSH.org or by visiting <http://bit.ly/KleinertFellowship>.

International Hand Surgery Fellowship

This new initiative offers junior hand surgeons in the United States the opportunity to participate in a 3-month fellowship in China or India. Participating fellows will gain hands-on operative experience on complex cases not seen in high volume in the U.S. We are grateful to our coordinators at the Sun Yat-sen University Hospital in Guangzhou, Feng Cheng Hospital in Xi'an, Jiao Tong University/Sixth People's Hospital in Shanghai, Huashan Hospital/Fudan University, Beijing, and the Ganga Hospital in Coimbatore for making this program possible.

This program is open to any ASSH Candidate Member who is completing an ACGME-accredited fellowship this year, or to practicing hand surgeons, up to five-years post-fellowship. The deadline to apply is June 15, 2017 and more information can be found on ASSH.org. Fellowships may begin as early as September 2017 and will conclude by end of May in 2018. We look forward to sharing stories and pictures from the selected fellows in a future ASSH Update.

SOUTH AFRICAN SOCIETY FOR SURGERY OF THE HAND

The South African Society has had an active year with our Annual Congress being held in Pretoria in August of 2016 and our Annual Refresher Course (Dupuytren's, infections and amputations) in Cape Town in February of this year.

We were lucky enough to have had a number of international guest speakers including Thomas Trumble, Martin Kirschner, David Warwick and Henk Giele visiting us for these meetings.

In addition Henk, with the help of some local faculty, ran a very successful flap cadaver dissection course in Stellenbosch.

The First SASSH/EWAS Wrist Arthroscopy Course was held at the Red Cross Children's Hospital in November. Christophe Mathoulin and his team of local and international faculty ran a basic wrist arthroscopy skills course that was well received and successful enough to suggest that this could become an annual feature on our educational calendar.

As a society we are most grateful to these international guests and their contribution to our society.

Regarding future plans; In February the Annual Refresher Course will be held in Pretoria. The topic is Hand and Wrist trauma and Randy Bindra is our international invited guest.

Roger Nicholson
President SASSH

SWITZERLAND SOCIETY FOR SURGERY OF THE HAND



Hand Surgery & Therapy at the Crossroad between Science and Craftsmanship

2016 was a special year for the Swiss Hand Surgery Society (SGH) – we celebrated our 50th birthday with a congress together with friends of the Belgian Hand Group, our therapists, therapists from Belgium and from The Netherlands. Our President, Michael Papaloizos, hosted this event in his home town Geneva, a city also known for its watch manufacturers. Getting an inside view of a famous watchmaker, the precise craftsmanship of a complicated clockwork was demonstrated and paralleled to the mandatory precision in hand surgery. While we exchanged science and craftsmanship during the interesting sessions, old and new friendships as well as our anniversary were celebrated with a memorable evening banquet in a very special environment – a velodrome – till late.



Impressions from the congress and the passing of the medal from the old president - Michael Papaloizos - to the new one - Mario Bonaccio

In our growing society of young hand surgeons and with increasing regulations from the authorities, teaching becomes more and more important. Only well trained hand surgeons may offer high quality treatment to their patients. But how can we get an excellent training in times, when working hours are continuously cut down, and the formal training period is restricted to 4 years? Teaching and learning as well as assessments should be performed in the context of the daily workplace, i.e. in the OR or in the Clinics. The members of the Swiss Hand Surgery board therefore have suggested the integration of more structured teaching in daily work. For example, in the OR, a procedure is started by a preoperative briefing for competence assessment between teacher and learner (including level of learner, indication of procedure with plan A or B, possible pitfalls) followed by a teaching or supervision process during surgery and finished by a postoperative debriefing after surgery. Basic surgical skills are automatically taught and assessed during procedures between expert and learner by a stimulating feedback system. This feedback system should be specific, measurable, attainable, relevant and time based (SMART) and leads to structured teaching with a positive impact on the learner's abilities. Young surgeons will get confidence under supervision. This project focuses on quality standards, in order to get continuous improvement of educating present and future members.

Esther Vögelin and Mario Bonaccio

TAIWAN SOCIETY FOR SURGERY OF THE HAND

The Taiwan Society for Surgery of the Hand (TSSH) was founded in 1990 and has members including orthopedic surgeons, plastic surgeons, general surgeons, and rehabilitation specialists. TSSH joined the IFSSH in 1994 and also became one of the founding societies of APFSSH. The TSSH continues to make important contributions to the field of hand surgery through research and in training.

TSSH holds an annual congress with prestigious international guest speakers. Each meeting is attended by 150~200 delegates. The 2017 annual congress of TSSH was different from previous congresses because of the collaboration with affiliated societies, including the Japanese Society for Surgery of the Hand (JSSH), Korean Society for Surgery of the Hand (KSSH), and Singapore Society for Surgery of the Hand (SSSH). Interesting topics and discussion were aroused by the participation of hand surgeons from Japan, Korea, Singapore and Taiwan. Beginning from the 2017 annual congress of TSSH, in the future there will be an annual "Asian-Pacific Session" hosted by the four affiliated societies mentioned above, in order to encourage young surgeons who are dedicated in the surgery of hand and upper extremity to present their work or research, and also to promote the friendship between different societies.

The "Continuous Medical Education (CME) in Hand Surgery" continues to run over a constantly updated 2-year cycle. These provide advanced teaching at a senior trainee or consultant level in hand surgery, with authorities in their specialized fields. The entire spectrum of orthopedic and plastic hand surgery is covered over the period and the courses are open to the members of TSSH. The CME courses were presented with lectures plus videos for demonstration of procedures.

Last but not the least, the website of TSSH has just been updated with a more friendly interface. Important announcements, schedules for CME and conferences are easily found on the website. CME powerpoint and video demonstrations could be downloaded from the website when logged in as a member. In addition, there is a new tab, "where to find hand surgeons in my city", for the general public to locate a well-trained and certified surgeon specialized in the field of hand and upper extremity surgery. Please visit us at the following address: <http://handsurgery.com.tw>

TURKISH SOCIETY FOR SURGERY OF THE HAND AND UPPER EXTREMITY

The Turkish Society for Surgery of the Hand and Upper Extremity was founded in 1977 by the honorary president, professor Rıdvan Ege. The society has 214 members, and it is a member of IFSSH and FESSH. The 2001 IFSSH meeting and the 2013 FESSH meeting were organized in Turkey by this society.

In 2009, hand surgery subspecialty education arrangements were made with a two year training period, following the Orthopedics and Traumatology or Plastic and Reconstructive Surgery Department residency programme. The subspecialty qualification is confirmed by a jury, which consists of five academic persons, following an approved thesis.

The Society has had its own hand surgery education curriculum since 2011. Hand Surgery diplomas have been given by the Ministry of Health to 130 hand surgeons between 2011 and 2012, and hand surgery became a certified subspecialty in Turkey.

The Turkish Society for Surgery of the Hand and Upper Extremity has also published the "Hand and Microsurgery" Journal since 2012, and accepts manuscripts in English.

VENEZUELAN SOCIETY FOR SURGERY OF THE HAND AND UPPER LIMB RECONSTRUCTION

The beginnings of the Venezuelan Society for Surgery of the Hand and Upper Limb Reconstruction (VSSH) go back to the city of Caracas in 1963, when MD. Ricardo Sánchez Beaujon and his medical team of the Ildemaro Salas Hospital, were transferred from Block 5 of the Silencio to the Military Hospital Carlos Arvelo, where they started the first consultations for hand surgery patients in the country.

In 1970 the MD. Miguel Pérez Carreño Hospital was inaugurated in el Pescozon, where MD. Ricardo Sánchez Beaujon then created the first Hand Surgery and Upper Limb Reconstruction service in Venezuela. A training program commenced here in 1975, receiving academic recognition from the Central University of Venezuela from 1978 onwards. Over the last 42 years highly trained professionals in our specialty have graduated from this facility.



Staff of the Hand Surgery and Upper Limb Reconstructive Service of the MD. Miguel Perez Carreño Hospital. Caracas, Venezuela. Teachers: MDs; Alex Quintero, Jose Duran, Rosa Mitrotti and Lyndon Franco and President SVCMRMS MD Jose Vicari. Residents: MDs; Rafael Esis, Biagio Sgro, Yaretzi Torrealba, Lisette Irausquin, Florangel Canaan and Gustavo Vernice.

It is also noteworthy that in 1974 MD. Ricardo Sánchez Beaujon was one of the founding members of our Society, which is celebrating its 43 years foundation this year.

The XLIII Venezuelan Meeting of Hand Surgery and Upper Limb Reconstruction will be held in Caracas from 20 to 22 July 2017 in honor of MD. Nelson Enrique Socorro Medina, pioneer of our specialty in the west of the country. International speakers will participate, including: MD Luis Náquira, Jairo Gomez, Edgar Pinilla and Fabio Suarez from Colombia, Pedro Delgado from Spain, Jorge Clifton from Mexico, Ricardo Madrea from

Argentina, Ricardo Kempf from Brazil, and Gustavo Lopez from Guatemala.

As a regional Society, the VSSH participated fully in the programme of the International Federation of Societies for Surgery of the Hand (IFSSH) Congress in October 2016, Buenos Aires, Argentina. At this meeting Dr. Jose Rafael Camarillo Morillo and Dr. Rodolfo Contreras Gamboa were awarded 'IFSSH Pioneer of Hand Surgery' status – a recognition that fills us with great pride and gives us reasons to continue with the activities of our specialty to benefit our patients.



Recognition of MD: José Rafael Camarillo Morillo and MD: Rodolfo Contreras Gamboa as IFSSH Pioneers of Hand Surgery, 2016

Journal Highlights

Below is a selection of contents pages from the latest issues of the following leading hand surgery journals.

JOURNAL OF HAND SURGERY EUROPEAN (VOLUME 42, ISSUE 3, MARCH 2017)

- Clarity and brevity: writing an article for this Journal
G. Hooper, J. B. Tang, R. G. Wetherell
pp. 231–239
- Dorsal intercalated segmental instability associated with malunion of a reconstructed scaphoid
J.-H. Kim, K.-H. Lee, B. G. Lee, C.-H. Lee, S.-J. Kim, W.-S. Choi
pp. 240–245
- Four-corner arthrodesis employing the native scaphoid as the principal donor graft for advanced collapse deformity of the wrist: technique and outcomes
S. M. Koehler, C. P. Melone
pp. 246–252
- Radial shortening osteotomy for treatment of Lichtman Stage IIIA Kienböck disease
M. Luegmair, F. Goeltz, K. Kalb, J. Cip, J. van Schoonhoven
- Intra-articular comminution worsens outcomes of distal radial fractures treated by open reduction

and palmar locking plate fixation
J. O. Yoon, S. L. You, J. K. Kim
pp. 260–265

- Do volar locking plates fit the volar cortex of the distal radius?
D.-S. Kwak, J.-Y. Lee, J.-H. Im, H.-J. Song, D. Park
pp. 266–270

- Magnetic resonance imaging investigation of radio-lunate relations: use in assessing distal radial fracture reduction
G. Medlock, J. M. Wohlgemut, I. M. Stevenson, A. J. Johnstone
pp. 271–274

- Prevalence of decompression surgery in patients with carpal tunnel syndrome 8 years after initial treatment with a local corticosteroid injection
A. Hameso, J. D. P. Bland
pp. 275–280

- Nerve grafts bridging the thenar branch of the median nerve to the ulnar nerve to enhance nerve recovery: a report of three cases
B. Gesslbauer, G. J. Furtmüller, O. Schuhfried, A. D. Roche, M. Sporer, O. C. Aszmann
pp. 281–285

- Commentary on 'Nerve grafts

bridging the thenar branch of the median nerve to the ulnar nerve to enhance nerve recovery: a report of three cases'

J. Isaacs
pp. 286–288

- Surgical site infection after hand surgery outside the operating theatre: a systematic review
N. A. Jagodzinski, S. Ibish, D. Furniss
pp. 289–294

- Successful conservative treatment outcomes and clinical characteristics of congenital hypoplasia of the extensor tendon central slip
N. Hidaka, T. Uemura, H. Nakamura
pp. 295–300

- Recovery, responsiveness and interpretability of patient-reported outcome measures after surgery for Dupuytren's disease
J. N. Rodrigues, W. Zhang, B. E. Scammell, D. Davidson, S. Fullilove, I. Chakrabarti, P. G. Russell, T. R. C. Davis
pp. 301–309

- Chrome nitride coating reduces wear of small, spherical CrCoMo

metal-on-metal articulations in a joint simulator

R. Thorkildsen, O. Reigstad, M. Røkkum
pp. 310–315

- Traumatic midcarpal dislocation in an 8-year-old girl
P. Diaz-Gallardo, F. Soldado, C. Allende
pp. 316–317

- Dart throwers motion may be optimal after scapholunate interosseous ligament reconstruction
F. W. Werner, P. A. Mohun, B. J. Harley
pp. 318–319

- Severe phlegmon of the upper extremity with digital necrosis after a cat scratch
A. Żyluk, P. Puchalski
pp. 319–320

- How to improve reviews for the Journal
Jin Bo Tang
pp. 321–322

- Hand surgery in Turkey
Gürsel Leblebicioğlu
pp. 323–323

JOURNAL OF HAND SURGERY AMERICAN (VOLUME 42, ISSUE 3, MARCH 2017)

- The Risk of Dupuytren Surgery in Obese Individuals
Jacques H. Hacquebord, Vicki Y. Chiu, Neil G. Harness
p149–155

- Fragment-Specific Fixation Versus Volar Locking Plates in Primarily Nonreducible or Secondarily Redisplaced Distal Radius Fractures: A Randomized Controlled Study
Marcus Landgren, Antonio Abramo, Mats Geijer, Philippe Kopylov, Magnus Tägil
p156–165.e1

- A Double-Blind Placebo Randomized Controlled Trial of Minocycline to Reduce Pain After Carpal Tunnel and Trigger Finger Release
Catherine M. Curtin, Debbie Kenney, Paola Suarez, Vincent R. Hentz, Tina Hernandez-Boussard, Sean Mackey, Ian R. Carroll
p166–174

- Use and Effectiveness of Ethyl Chloride for Hand Injections
Orrin I. Franko, Peter J. Stern
p175–181.e1

- Extended Posterior Interosseous Artery Flap: Anatomical and Clinical Study
Ezequiel Ernesto Zaidenberg, Efrain Farias-Cisneros, Martin Jose Pastrana, Carlos Rodolfo Zaidenberg
p182–189

- Comparison of Ultrasound-

Guided Axillary Brachial Plexus Block Properties in Diabetic and Nondiabetic Patients: A Prospective Observational Study
Emine Aysu Salviz, Sukru Onbasi, Anil Ozonur, Mukadder Orhan-Sungur, Omer Berkoz, Kamil Mehmet Tugrul
p190–197

- Total Wrist Arthroplasty
Andrea Halim, Arnold-Peter C. Weiss
p198–209

- Embedded Librarian as Research Team Member
Frances A. Brahmi, F. Thomas D. Kaplan
p210–212

- Cost Savings and Patient Experiences of a Clinic-Based, Wide-Awake Hand Surgery Program at a Military Medical Center: A Critical Analysis of the First 100 Procedures
Peter C. Rhee, Michelle M. Fischer, Laura S. Rhee, Ha McMillan, Anthony E. Johnson
e139–e147

- Volar Anatomy of the Proximal Phalanx: Implications for Screw Length Selection for Fixation of Shaft Fractures
P. Barrett Honeycutt, Edward W. Jernigan, Wayne A. Rummings Jr., Peter J. Stern, Reid W. Draeger
e149–e157

- Comparison of 2-Dimensional

and 3-Dimensional Metacarpal Fracture Plating Constructs Under Cyclic Loading

Eric P. Tannenbaum, Geoffrey T. Burns, Nikhil R. Oak, Jeffrey N. Lawton
e159–e165

● Diagnosis and Arthroscopic Management of Dorsal Wrist Capsular Impingement

Andrew P. Matson, Travis J. Dekker, Alexander J. Lampley, Marc J. Richard, Fraser J. Leversedge, David S. Ruch
e167–e174

● Static and Dynamic Handgrip Strength Endurance: Test-Retest Reproducibility

Vassilis Gerodimos, Konstantina Karatrantou, Dimitra Psychou, Theodora Vasilopoulou, Andreas Zafeiridis
e175–e184

● Impact of Distal Ulnar Fracture Malunion on Distal Radioulnar Joint Instability: A Biomechanical Study of the Distal Interosseous Membrane Using a Cadaver Model

Satoshi Miyamura, Atsuo Shigi, Jirachart Kraissarin, Shohei Omokawa, Tsuyoshi Murase, Hideki Yoshikawa, Hisao Moritomo
e185–e191

● Unusual Presentation of Infantile Myofibroma in the Deep Palm of a Child: A Case Report and Discussion of the Differential Diagnosis

Matthew S. Brown, Amer Heider, Kevin C. Chung
e193–e198

● Reticular Perineurioma of the Hand: Diagnosis and Treatment of a Rare Case of Hand Mass

Patrice Zaugg, Benoit Maeder, Antoine Nobile, Wassim Raffoul, Christof Bollmann, Pietro G. di Summa
e199–e203

● The Abductor Pollicis Longus Tendon as an Alternative Graft in Hand Surgery

Samuel Rosas, Carolina Mesa, Felipe Mesa
e205–e208

● Modified Long Toe Extensor Tendon Harvest for Use as Intercalary Graft in Upper Extremity Reconstruction

Michael P. Gaspar, Danielle M. Wilbur, Peter J. Stern, Randall W. Culp
e209–e213

JOURNAL OF HAND SURGERY ASIAN-PACIFIC (VOLUME 22, NO 01, MARCH 2017)

● Scaphotrapeziotrapezoidal Joint Osteoarthritis: A Systematic Review of Surgical Treatment

Victoria M. Deans, Zafar Naqui, Lindsay T.S.W. Muir
P1

● Finger Trauma Due to Surfing;

A Case Series and Analysis of Fracture Patterns

A.C.J. Ruijs, L.C. Langenberg, J. Rezzouk
P10

● Biomechanics of Internal Fixation Modalities for Middle Phalangeal Base Fracture Dislocation

Gen-Lin Foo, Amit K. Ramruttun, Andre Eujin Cheah, Alphonsus Kin-Sze Chong, Tun-Lin Foo
P14

● A Comparison of Two Monofilament Suture Materials for Repair of Partial Flexor Tendon Lacerations: A Controlled In-vitro Study

Abhinav Gulihar, Thomas Whitehead-Clarke, Ladan Hajipour, Joseph J. Dias
P18

● Vascularized Medial Femoral Condyle Bone Graft for Resistant Nonunion of the Distal Radius

Mark Henry
P23

● Plate Fixation versus Percutaneous Pinning for Unstable Metacarpal Fractures: A Meta-analysis

Eitan Melamed, LiJin Joo, Edward Lin, Donato Perretta, John T. Capo
P29

● Trans-metacarpal Screw Fixation for Extra-articular Proximal Phalangeal Base

Fractures

Eichi Itadera, Takahiro Yamazaki
P35

● Functional Outcomes of Antegrade Homodigital Neurovascular Island Flaps for Fingertip Amputation

Lin-Wing Lok, Wing-Leung Chan, Yan-Kit Lau
P39

● A New Classification Scheme for Closed Avulsion Injuries of the Flexor Digitorum Profundus Tendon

Mokhtar Abdul Azeem, Yousef Marwan, Ahmed El Morshidy, Ali Esmaeel, Yehia Zakaria
P46

● Trigonometry-Integrated 'Lift' Technique (TILT) for Restoring Volar Tilt in Distal Radius Fractures: Description of Technique and Preliminary Results

Sreedharan Sechachalam, Mala Satku, JianHao Kevin Wong, Lester Teong Jin Tan, Fok Chuan Yong
P53

● A Biomechanical Comparison of Different Knots Tied on Fibrewire

Suture

Jackson Jiang, Ita Suzana Mat Jais, Andrew Kean Tuck Yam, Duncan Angus McGrouther, Shian Chao Tay
P65

● Valgus Instability of the Elbow Due to Medial Epicondyle Nonunion: Treatment by Fragment Excision and Medial Collateral Ligament Reconstruction

Yasunori Kaneshiro, Noriaki Hidaka, Koichi Yano, Makoto Fukuda, Hideki Sakanaka
P70

● Asymptomatic Flexor Tendon Damages after Volar Locking Plate Fixation of Distal Radius Fractures

Susumu Tokunaga, Yoshihiro Abe
P75

● Arthrodesis of Little Finger Distal Interphalangeal Joint in Flexion to Regain Sporting Ability

S.M. Beecher, D.E. O'Briain, J.P. Ng, E. Murphy, M.E. O'Sullivan
P83

● An Experimental Survey on the Effect of Using the CTS-6 Tool on the Diagnosis of Carpal Tunnel Syndrome by Hand Surgeons

Richard L. Hutchison, Alan L. Hutchison, Maureen A. Hirthler
P88

● Extensor Tendon Instability Due to Sagittal Band Injury in a Martial Arts Athlete: A Case Report

Andrew Kochevar, Ghazi Rayan

P93

● A Giant Deep-seated Lipoma in a Child's Forearm
Svetoslav A. Slavchev, Georgi P. Georgiev
P97

● Utility of Magnetic Resonance Imaging in the Surgical Management of Drug Extravasation: A Case Report
Yet Yen Yan, Tein Jin Tan
P100

● Peripheral Nerve Lymphomatosis
Tun-Lin Foo, Ryan Yak, Mark E. Puhaindran
P104

● Dynamic Ulnar Drift of Single Digit by an Anomalous Accessory Extensor Tendon
James R.A. Smith, Rouin Amirfeyz
P108

● A Rare Case of Primary Tuberculous Tenosynovitis in a Young Patient with an Acute History
Alistair J.M. Reed, Jeremy N. Rodrigues, Sharif Al-Ghazal, Zakir Shariff
P111

● A Novel Surgical Technique for Chronic Mallet Finger Injury: A Case Report
Taku Suzuki, Naoto Inaba, Kazuki Sato
P114

● Isolated Dislocation of Fourth Carpometacarpal Joint: Case Report

K.P. Venkatesh, B. Sunil, N.V. Ankith, Anupama B.R.
P118

JOURNAL OF HAND THERAPY (VOLUME 30, ISSUE 1, JANUARY-MARCH 2017)

● Have we missed the point of cross-cultural translation?

Editorial
p1–2

● Is there a relationship between impaired median nerve excursion and carpal tunnel syndrome? A systematic review

Richard Ellis, Rebecca Blyth, Nick Arnold, Warren Miner-Williams
p3–12

● Comparison of effects of eccentric training, eccentric-concentric training, and eccentric-concentric training combined with isometric contraction in the treatment of lateral elbow tendinopathy

Dimitrios Stasinopoulos, Ioannis Stasinopoulos
p13–19

● Effects of a stretching protocol for the pectoralis minor on muscle length, function, and scapular kinematics in individuals with and without shoulder pain

Dayana P. Rosa, John D. Borstad,

Livia S. Pogetti, Paula R. Camargo
p20–29

● A user's survey of the clinical application and content validity of the DASH (Disabilities of the Arm, Shoulder and Hand) outcome measure

Carol A. Kennedy, Dorcas E. Beaton
p30–40.e2

● A retrospective cohort study of QuickDASH scores for common acute trauma conditions presenting for hand therapy

Mikayla Southam, Susan Driessens, Christopher Burton, Rodney Pope, Penelope Thurnwald
p41–48

● The Southampton Hand Assessment Procedure revisited: A transparent linear scoring system, applied to data of experienced prosthetic users

Johannes G.M. Burgerhof, Ecaterina Vasluian, Pieter U. Dijkstra, Raoul M. Bongers, Corry K. van der Sluis
p49–57

● Patient-reported outcomes after open carpal tunnel release using a standard protocol with 1 hand therapy visit

Erin M. Mack, Nancy J. Callinan, Megan Reams, Deborah C. Bohn, Terese L. Chmielewski
p58–64

● Determining the functional sensibility of the hand in patients

with peripheral nerve repair: Feasibility of using a novel manual tactile test for monitoring the progression of nerve regeneration
Hsiu-Yun Hsu, Li-Chieh Kuo, Ta-Shen Kuan, Hsiu-Ching Yang, Fong-Chin Su, Haw-Yen Chiu, Shyh-Jou Shieh
p65–73

● Factors affecting the results of the functional dexterity test

Fusun Şahin, Nilgün Şimşir Atalay, Nuray Akkaya, Sibel Aksoy
p74–79

● Analyzing finger interdependencies during the Purdue Pegboard Test and comparative activities of daily living

Victor Gonzalez, Jennifer Rowson, Alaster Yoxall
p80–88

● Camera-tracking gaming control device for evaluation of active wrist flexion and extension

Dalit Shefer Eini, Navah Z. Ratzon, Albert A. Rizzo, Shih-Ching Yeh, Belinda Lange, Batia Yaffe, Alexander Daich, Patrice L. Weiss, Rachel Kizony
p89–96

● The sensory function of the uninjured nerve in patients after median and ulnar nerve injury

Marcin Ceynowa, Rafał Pankowski, Marek Roślowski, Tomasz Mazurek
p97–103

● Clinical relevance commentary in response to: The sensory function of the uninjured nerve in patients after median and ulnar nerve injury

Kristin Valdes
p104–105

● Use of Dexteria application to improve fine motor coordination in the nondominant hand

Nathan Short, Rachel Harmsen, Grace Kjellgren, Chelsie O'Neill, Holly Pinney, Andrew D. Rivera, Victoria Warnaar
p106–108

● Wrist extension or flexion mobilization orthosis: The dinosaur design

Sarah Arnold, Robin Janson
p109–112

● A simple orthosis solves a problem in a patient with a dystonic finger after stroke

Stefano Vercelli, Giorgio Ferriero, Elisabetta Bravini, Wafa Al Yazeedi, Ludovit Salgovic, Marco Caligari, Francesco Sartorio
p113–115

● Short thumb opponens orthosis: A whale of a design

R. Cantero-Téllez, Deborah A. Schwartz, Jorge Hugo Villafañe, Jean Christophe Arias
p116–120

● Comparative study of millennials (age 20–34 years) grip and lateral pinch with the norms

Michael Hollmann, Frank Schifferdecker-Hoch
e1

● Comment on "Patient-reported outcomes after open carpal tunnel release using a standard protocol with 1 hand therapy visit"

Daniele Coraci, Valter Santilli, Silvia Giovannini, Luca Padua
e3–e4

● Response to "Comment on 'Patient-Reported Outcomes following Open Carpal Tunnel Release using a Standard Protocol with One Hand Therapy Visit'"

Deborah C. Bohn, Erin M. Mack
e5

JOURNAL OF WRIST SURGERY (VOLUME 06, ISSUE 1, FEBRUARY 2017)

● Kienböck Disease: A New Algorithm for the 21st Century

Lichtman, David M.; Pientka, William F.; Bain, Gregory Ian:
p002

● Combined Tenodesis–Capsulodesis for Scapholunate Instability: Minimum 2-Year Follow-Up

De Carli, Pablo; Donndorff, Agustin G.; Torres, Miguel Tovar; Boretto, Jorge G.; Gallucci, Gerardo L.
p011

● Characterization and Epidemiology of the Carpal Boss

Utilizing Computed Tomography
Goiney, Christopher; Porrino, Jack; Richardson, Michael L.; Mulcahy, Hyojeong; Chew, Felix S.: Full Text
p022

● Preventable Repeat Wrist Arthroscopies: Analysis of the Indications for 133 Cases

Löw, Steffen; Spies, Christian K.; Unglaub, Frank; van Schoonhoven, Jörg; Prommersberger, Karl-Josef; Mühlendorfer-Fodor, Marion
p033

● The Oblique Metaphyseal Shortening Osteotomy of the Distal Ulna: Surgical Technique and Results of Ten Patients

Benis, Szabolcs; Goubau, Jean F.; Mermuys, Koen; Van Hoonacker, Petrus; Berghs, Bart; Kerckhove, Diederick; Vanmierlo, Bert:
p039

● AO Distal Radius Fracture Classification: Global Perspective on Observer Agreement

Jayakumar, Prakash; Teunis, Teun; Giménez, Beatriz Bravo; Verstreken, Frederik; Di Mascio, Livio; Jupiter, Jesse B.:
p046

● Distal Radius Fractures Do Not Displace following Splint or Cast Removal in the Acute, Postreduction Period: A Prospective, Observational Study

Foster, Brock D.; Sivasundaram, Lakshmanan; Heckmann,

Nathanael; Pannell, William C.; Alluri, Ram K.; Ghiassi, Alidad: p054

● Microfracture for Ulnar Impaction Syndrome: Surgical Technique and Outcomes with Minimum 2-Year Follow-up
Kaufman, David; Etcheson, Jennifer; Yao, Jeffrey
p060

● Meniscal Allograft Interposition Combined with Proximal Row Carpectomy
Steiner, Murphy M.; Willsey, Matthew R.; Werner, Frederick W.; Harley, Brian J.; Klein, Shay; Setter, Kevin J.:
p065

● Isolated Tuberculosis of Capitate and Triquetrum
Karakaplan, Mustafa; Köroğlu, Muhammed; Ergen, Emre; Aslantürk, Okan; Özdemir, Zeynep Maraş; Ertem, Kadir
p070

● Ulna Rotation Osteotomy in Complete Dislocation of the Distal Radioulnar Joint
Gabl, Markus; Arora, Rohit; Gassner, Eva Maria; Schmiddle, Gernot:
p074

xx

● The PARC Lesion: A Proximal Avulsion of the Radiocarpal Capsule
Bonte, Francis; Mathoulin, Christophe L.
p080

HAND CLINICS (MAY 2017 VOLUME 33, ISSUE 2)

● Optimizing the Treatment of Burn Injuries of the Upper Extremity
Jason H. Ko, Benjamin Levi

● Acute Management of Hand Burns
Ashwin Soni, Tam N. Pham, Jason H. Ko

● Management of Acute Pediatric Hand Burns
William B. Norbury, David N. Herndon

● A 3-Phase Approach for the Management of Upper Extremity Electrical Injuries
Ketan Sharma, Miles Bichanich, Amy M. Moore

● Cold Injuries
Deana S. Shenaq, Lawrence J. Gottlieb

● The Use of Dermal Skin Substitutes for the Treatment of the Burned Hand
Ian C. Sando, Kevin C. Chung

● Biological Principles of Scar and Contracture
Peter O. Kwan, Edward E. Tredget

● Postburn Upper Extremity Occupational Therapy
Tiffany Williams, Tanya Berenz

● Scar Management of the Burned

Hand

Michael Sorkin, David Cholak, Benjamin Levi

● Postburn Contractures of the Hand
Matthew Brown, Kevin C. Chung

● Reconstruction of the Adult and Pediatric Burned Hand
Ryan P. Cauley, Lydia A. Helliwell, Matthias B. Donelan, Kyle R. Eberlin

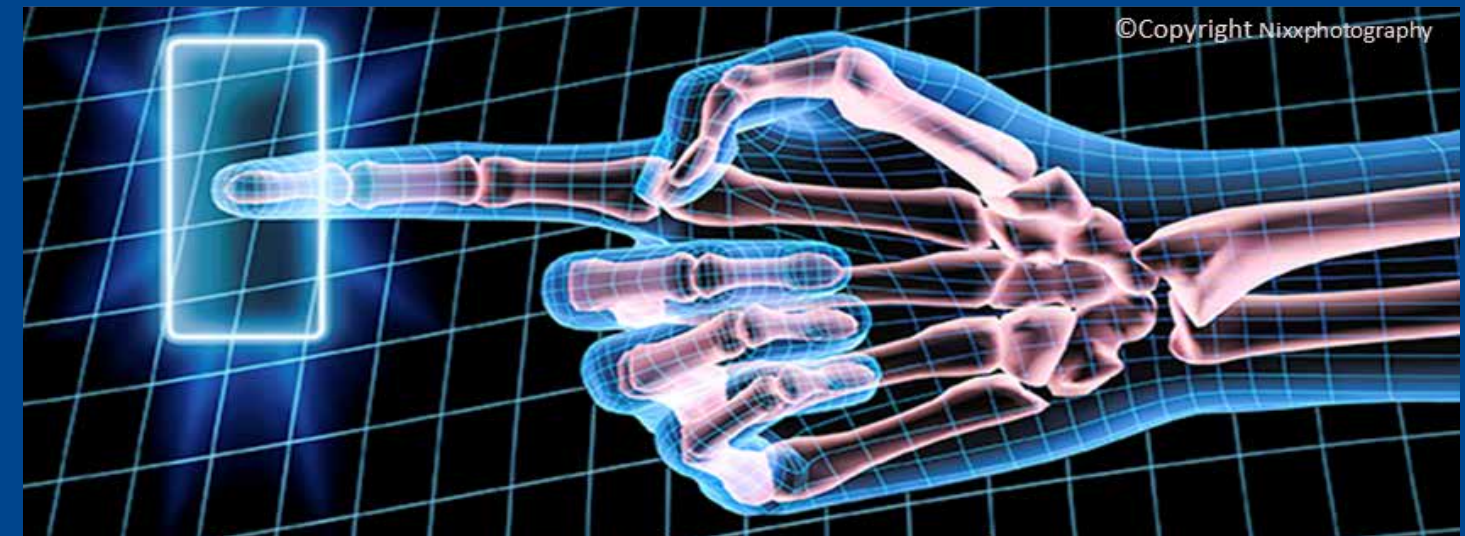
● Microsurgical Reconstruction of the Burned Hand and Upper Extremity
Mauricio De la Garza, Michael Sauerbier, Germann Günter, Curtis L. Cetrulo Jr., Reuben A. Bueno Jr., Robert C. Russell, Michael W. Neumeister

● Heterotopic Ossification Following Upper Extremity Injury
Shailesh Agarwal, Shawn Loder, Benjamin Levi

● Postburn Contractures of the Elbow and Heterotopic Ossification
Mary Claire Manske, Douglas P. Hanel

● Outcomes Assessment After Hand Burns
Shepard P. Johnson, Kevin C. Chung

● International Disease Burden of Hand Burns
Daniel S. Corlew, K.A. Kelly McQueen



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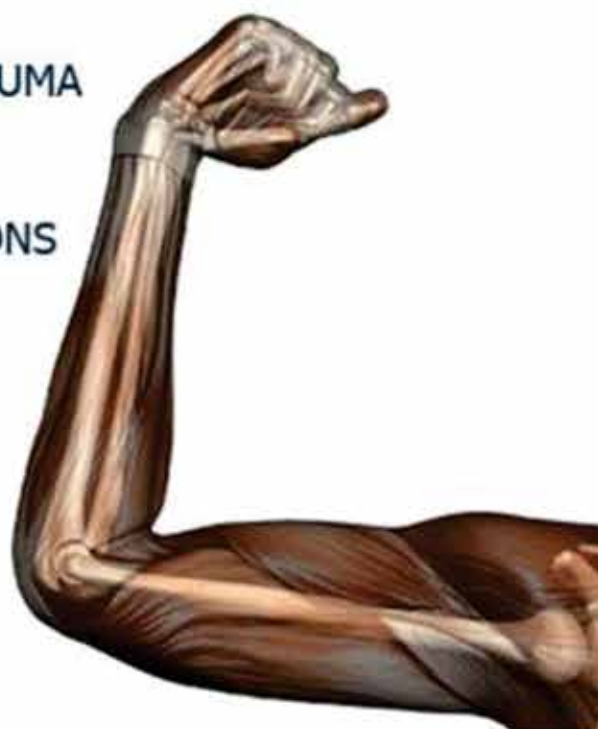
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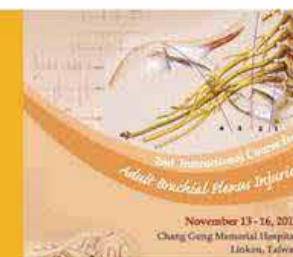
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Congress Venue
Hotel Andrásy Residence
H-3915 Tarcál, Hungary
Fő u. 94.

Topics

- | | |
|-------------------------------------|--|
| 1) assessment | 6) reconstruction of intrinsic |
| 2) anatomy and biomechanics | 7) nerve transfers |
| 3) suture technique | 8) new developments |
| 4) reconstruction of elbow extensor | 9) spasticity control |
| 5) reconstruction of grip and grasp | 10) rehabilitation |
| | 11) clinical examination and case discussion |

Registration deadline: 1 June 2017

Registration fees	
Therapists fee	650 EUR
Surgeons fee	950 EUR

For more information and registration please visit the congress website

Best wishes,
ASSZISZTENCIA Congress Bureau
Congress Secretariat

H-1055 Budapest, Hungary
Szent István krt. 7
Phone: +36 1 350-1854
Fax: +36 1 350-0929
E-mail: tetraplegia@asszisztencia.hu
Web: www.asszisztencia.hu/tetraplegia/2017



home iscrizione la societa' formazione corsi e congressi fotogallery e video

We are writing on behalf of the Italian Society for Microsurgery to inform you of the

7th INTERNATIONAL DISSECTION COURSE ON RECONSTRUCTIVE MICROSURGERY PERIPHERAL NERVE SURGERY AND TENDON TRANSFER CAD LAB

that will be held at the Miguel Hernandez University in San Juan de Alicante (Spain) on June 5th – 7th 2017, part of the teaching programme of the Italian Society for Microsurgery.

For further information you can [click here](#) or access the Course Website <http://www.arm2017.net>.
You can contact us directly at info@studioprogress.it.

We are at your disposal for any further information you may require.

Best regards.

The Organizing Secretariat
StudioProgress snc

SIM - Società Italiana di Microchirurgia

Sede Legale e Sede Organizzativa: StudioProgress - Via C. Cattaneo, 51 - 25121 Brescia - Italia

tel. 030290326 - fax 03040164

E-mail: segreteria@microchirurgia.org - Web: www.microchirurgia.org



Registration for the **2017 ASSH Annual Meeting** in San Francisco, CA is open. The meeting will be held September 7 - 9 at the Moscone West Convention Center. Visit the [ASSH Annual Meeting website](#) to learn more about the program, and register soon to take advantage of early bird pricing.





AACM



Asociación Argentina de Cirugía de la Mano
y Reconstructiva del Miembro Superior

2017

Viernes 9^o Junio
Sábado 10^o Junio

43^o Curso de Actualización en Cirugía de la Mano y Miembro Superior

"Cuando lo simple se complica"

Presidente AACM
Dr. Cecilio Argañaraz
Secretario General
Christian Perrotto
Secretario Científico
Guillermo Maujo

Inscripción ONLINE
Cierre: 25/5

Centro Cultural
Parque de España
ROSARIO, SANTA FE

VENUES

13th March, 2018 (Lecture)
Auditorium 9th Floor, Centre of Clinical Medicine,
Lerdsin Hospital, Bangkok, Thailand

14th March, 2018 (Cadaveric Workshop)
Siriraj Training and Education Center for Clinical Skills (SITEC),
Srisavardindra Building, Siriraj Hospital, Bangkok, Thailand

ACCOMMODATION

Holiday Inn Hotel : Just the Place for you

13th March 2018 : 4-min walk from hotel to Lerdsin Hospital

14th March 2018 : Free shuttle bus service is provided for all participants of
3rd Dissection Course 2018
<http://www.holidayinn.com/siam>

REGISTRATION FEE

Early Registration (Before 31st Dec 2017) 1,200 USD
Late Registration (1st Jan 2018 - 12th March 2018) 1,500 USD

CONTACT US

Secretariat Office : Institute of Orthopaedics, Lerdsin Hospital

190 Silom Rd., Bangrak, Bangkok 10500, Thailand

+66 2353 9644 / Fax : +66 2353 9645

<http://www.thaishs.org/conference/bpc2018/>

bpc2018@gmail.com

PROGRAM

3rd Brachial Plexus cadaveric Dissection Course 2018

The Thai Society for Surgery of the Hand
13th-14th March 2018 : Bangkok, Thailand

Tuesday 13th March, 2018

8.00-8.10	Opening Ceremony	Dr. Lim
8.10-8.20	Anatomy of Brachial Plexus	Dr. Panupan
8.20-8.30	Past-Present-Future of Adult Brachial Plexus Injury	Dr. Lim
8.30-8.40	Role of Nerve Grafting in Adult Brachial Plexus	Dr. Ng
8.40-8.50	Shoulder Biomechanics	Dr. Torphon
8.50-9.00	Spinal Accessory Nerve Transfer to Suprascapular Nerve	Dr. Oberlin
<i>Anterior Approach - Posterior Approach</i>		
9.00-9.10	Intercostal Nerve Transfer to Suprascapular Nerve	Dr. Oberlin
9.10-9.20	Shoulder Arthrodesis	Dr. Oberlin
9.20-9.30	Tendon Transfer for Shoulder Function	Dr. Anil
9.30-9.40	Serratus Anterior Dysfunction and Management	Dr. Ng
9.40-9.50	Thoracodorsal Nerve Transfer to Long Thoracic Nerve	Dr. Somsak
<i>9.50-10.10 Discussion / 10.10-10.30 Break</i>		
10.30-10.40	Nerve Transfer for Deltoid Reconstruction	Dr. Somsak
10.40-10.50	Late Nerve Transfer for Shoulder Function	Dr. Oberlin
10.50-11.00	Oberlin's Method : 25 Years Experience	Dr. Oberlin
11.00-11.10	Intercostal Nerve Transfer for Elbow Flexion	Dr. Preecha
11.10-11.20	Free Functional Muscle Transfer in BPI	Dr. Tu
11.20-11.30	Direct Contralateral C7 Transfer	Dr. Tu
11.30-11.40	Contralateral C7 Transfer (Indian Experience)	Dr. Anil
11.40-11.50	FFMT for Chronic Total Arm Type BPI	Dr. Saichon
11.50-12.00	Reconstruction of Hand in BPI	Dr. Oberlin
<i>12.00-12.10 Discussion / 12.30-13.30 Break</i>		
13.30-13.40	Natural History and Clinical Evaluation of OBPP	Dr. Anil
13.40-13.50	Strategy of OBPP Treatment	Dr. Oberlin
13.50-14.00	Role of Nerve Transfer in OBPP	Dr. Kanchai
14.00-14.10	Late Reconstruction Elbow/Wrist and Hand in OBPP	Dr. Oberlin
14.10-14.20	How to Management Shoulder Problem in OBPP	Dr. Anil
14.20-14.30	Role of Nerve Transfer in Tetraplegic Patient	Dr. Karit
14.30-14.40	Management of Pain in Brachial Plexus Injury	Dr. Saranath
14.40-14.50	Designs in Innervation of Upper Limb Muscles	Dr. Lim
<i>14.50-15.10 Discussion / 15.10-15.30 Break</i>		
15.30-16.30	Case Discussion	

3rd

BRACHIAL PLEXUS CADAVERIC DISSECTION COURSE 2018



The Thai Society for Surgery of the Hand
13th-14th March 2018 : Bangkok, Thailand
<http://www.thaishs.org/conference/bpc2018/>

WELCOME MESSAGE



"After the great success of cadaveric surgical workshop on management of brachial plexus injury in the year of 2012 and 2015 at Bangkok Thailand, on behalf of the organizing committee, I have the great pleasure to invite all of you to join the third occasion for cadaveric workshop in the theme "surgical management of brachial plexus injury problems". It will be held in Bangkok at during March 13-14, 2018. We have gathered a group of experienced brachial plexus surgeons with varied geographic and educational background who will present a balanced view of their subjects, emphasizing their own personal choice of treatment. Many interesting and great cadaveric practicing programs are arranged by the gliding instructors. The workshop will become an energy platform as well as a most path toward better understanding, greater intercommunication between in the field of the attendants and instructors in brachial plexus injury. I would like to express my gratitude and warmly welcome all to Thailand as well as many thanks to committee and instructors."

Preecha Chalidapong Chairman, the organizing committee



"First and foremost, I would like to take great pleasure in welcoming you to the beautiful country of our Thailand. I am delighted to invite all of the delegates to participate in our 3rd brachial plexus cadaveric workshop. There will be renowned overseas faculty and within Thailand with emphasis on personal interaction of the delegate with the faculty. We are looking forward to seeing you in Bangkok in March 2018."

Somsak Leechavengrongs President of The Thai Society for Surgery of the Hand

INTERNATIONAL SPEAKERS

- Prof. Christophe Oberlin : France
- Prof. Yuan-Kun Tu : Taiwan
- Dr. Anil Ghanshyam Bhatia : India
- Prof. Aymeric Lim : Singapore
- Dr. Chiye Yee Ng : England

Wednesday 14th March, 2018 Cadaveric Workshop : 30 minutes each

1. Suprascapular approach Dr. Panupan & Dr. Sunyern
2. Intracapsular approach Dr. Oberlin & Dr. Nattawat
3. Medial arm approach (include Oberlin's transfer) Dr. Oberlin & Dr. Arakphal
4. Intercostal nerve dissection Dr. Preecha & Dr. Kilewan
5. Pronator quadratus nerve transfer Dr. Karit & Dr. Praisit
6. Free functioning muscle transfer Dr. Tu & Dr. Thepparat
7. Nerve to long head triceps to axillary nerve - Posterior approach Dr. Somsak & Dr. Navapong
8. Thoracodorsal nerve to long thoracic nerve Dr. Kanchai & Dr. Dechpoom
9. Contralateral C7 nerve transfer Dr. Tu & Dr. Anil
10. Spinal accessory nerve to supra scapular nerve - Posterior approach Dr. Torphon & Dr. Roongsak
11. Distal motor nerve transfer for wrist and finger extension Dr. Karit & Dr. Jirachart





SAVE THE DATES

15 AVRIL
APRIL 15thOuverture de la plateforme de
soumission d'abstracts
Opening of abstracts submission
platform15 JUIN
JUNE 15thClôture de la soumission des
abstracts
Closing of submission platform2 NOVEMBRE
NOVEMBER 2ndFin du tarif
préférentiel
End of early bird
feeTéléchargez la 1^{ère} annonce
Download 1st announcement!

Chers Amis, L'année 2017 durant laquelle j'aurai eu l'honneur et la fierté de présider la SFCM, se terminera par notre congrès annuel. Du fait de la proximité des Fêtes de Noël, les dates traditionnelles du congrès ont été fixées du lundi 18 décembre à 14h au mercredi 20 décembre 18h30. Cela facilitera votre participation qui nous l'espérons sera toujours plus nombreuse. Le programme du congrès sera, je le pense, aussi varié que passionnant. Vous pourrez y contribuer activement par une communication orale, un e-poster ou une vidéo-flash en soumettant votre abstract entre le 15 avril et le 15 juin.

Les conférences d'enseignement auront comme sujet: le traitement des pertes de substances pulpaire et de la face palmaire des doigts, des raideurs digitales, des pseudarthroses du scaphoïde, des transferts articulaires vascularisés à la main, de la biologie du développement embryonnaire de la main et enfin des implants en pyrocarbone à la main et au poignet. Notez que cette dernière conférence permettra de clôturer votre DPC 2017 que je vous incite à valider avec la SFCM directement sur son site sfcml.fr avant le 30 avril prochain.

La Suisse sera notre invitée d'honneur. Une délégation, constituée d'Esther Vögeli, Maurizio Calgagni, Daniel Herren, Ladi Nagy, Michael Papaloizos et Stephen Schingele, partagera avec nous sous forme de mini-conférences et de débat-controverses leurs expériences souvent originales. Aymeric Lim, autre invité étranger de Singapour, nous exposera l'anatomie des transferts nerveux.

Les tables rondes et symposia tenteront de faire le point et de dégager...

[Affichez l'édito complet / View full edito](#)

Philippe Bellemère
Président de la SFCM 2017
*Société Française de Chirurgie de la Main
WebSite : <http://www.sfcml.fr>



ISSHCON 2017

21st, 22nd, 23rd September 2017 (Thu, Fri, Sat)

41st Annual conference of Indian Society for Surgery of the Hand
co hosted by Singapore Society for Hand Surgery



Register Online
at
www.ishcon2017.com
or mail to
admin@ishcon2017.com

Feel the Aura,
Dine with the Masters!
Workshops,
Master Class,
Symposia & more!

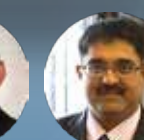
.....and
world renowned
Faculty from
Singapore &
India



Prof R Venkataswami Oration
'Distal End Radius – 2017'
Prof Richard Gelberman, USA



Dr B B Joshi Oration
'New Horizons in treatment
of Upper Limb Paralysis
following Spinal Cord Injury'
Prof Jayme Bertelli, BRAZIL

Dr Jeff Ecker
AustraliaProf Max Haerle
GermanyProf Sanj Kakar
USADr Sumedh T
UKDr Sunil TM
USADr Sebastin S
SingaporeDr Andrea Atzei
Italy

• 8 simultaneous workshops

- Tendon Repair
- Flaps in the Hand
- Anchors in Hand & Wrist
- DER & Scaphoid Fixation
- MC & Phalanges Fixation
- ECTR & 1st CMC joint
- EMG NC demonstration
- Splint Making

• Breakfast Sessions

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CONTACT

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Dr Rohan Habbu	98207 27963
Dr Parag Lad	88791 00395
Dr Bipin Ghanghure	77387 29068
Dr Nilesh Satbhai	97692 71549
Dr Kiran Ladkat	98195 30321

VENUE: J W MARRIOTT, JUHU TARA ROAD, JUHU, MUMBAI - 400049

Event Manager: VAMA Events Pvt. Ltd

Email: vamahospitality@hotmail.comWebsite: www.vamaevents.com

Phone: +91-22-2438 3498



Registration is now open!

www.sympo-pediatric-hand-2017.com

REGISTRATION FEES	Up to March 15th 2017	After March 15th 2017
Consultants	390 €	450 €
Fellows, Trainees, Hand Therapists	190 €	250 €

THEMES

Embryology and Comparative Anatomy

- EVO-DEVO
- Developmental Biology

Congenital Malformations

(Surgical management, Hand Therapy, Psychological aspects)

- Hand and Upper limb
- Forefoot

Pediatric upper limb traumas

- Fractures, dislocations, growth disorders
- Burn
- Rehabilitation

Tumors and Tissue Dysplasia

- Skin, soft tissue, bone
- Vascular anomalies

Genodermatosis

- Dystrophic Epidermolysis Bullosa

Hand Therapy and splinting in Children

Humanitarian projects

Workshops on splinting, Ergotherapy

Download
PROGRAMME

[image006.png](#)

website
CLICK HERE

ORGANISATION / CONTACT

eventime

44 Boulevard Périer 13008 Marseille
Tel: +33 (0)4 91 94 54 72 contact@sympo-pediatric-hand-2017.com



Call for Abstracts

The Asia Pacific Wrist Association (APWA) invite you to submit abstracts for the

APWA 3rd Annual Congress - 6-8 October 2017 - Adelaide, Australia.

It promises to be an exciting meeting with a strong international scientific program.

The Asia Pacific Wrist Association is a non-profit international scientific association open to all individuals involved or interested in disorders of the wrist and its surgical and non-operative management.

APWA 2017 is aimed at hand surgeons, trainees, students and hand therapists.

The conference will be at the "state of the art" Flinders Advanced Surgical Training facility at **Tonsley Campus of Flinders University**. **Cadaveric demonstrations** will be beamed from the Cadaveric Lab to the Lecture Theatre. This will enable the attendees to witness the quality faculty demonstrate principles of anatomy, examination and surgery. Lectures and panel discussions will follow.

You're invited to participate in this prestigious academic event in Adelaide, in October 2017.

Yours sincerely

Greg Bain

Professor of Upper Limb Surgery and Research
Flinders University, Adelaide, South Australia
Chair – APWA 2017, Adelaide



Faculty International

Alejandro Badia (USA)
Tyson Cobb (USA)
Marc Garcia Elias (Spain)
Diego Fernandez (Switzerland)
Max Haele (Germany)
Phillippe Livernaux (France)
Steve Moran (USA)
Nash Naam (USA)
Jorge Orbay (USA)

Hand Therapy

Joy McDermid (Canada)
Josephine Wong OT (Hong Kong)
Polina Yeung PT (Hong Kong)

Asia Pacific

Greg Bain (Australia) Chairman
PC Ho (Hong Kong) APWA President
Toshi Nakamura (Japan) V President
Wen Dong Xu (China), V President
Wei-jen Chen (Taiwan)
Andrew Chin (Singapore)
Jeff Ecker (Australia)
Margaret Fok (Hong Kong)
Keiji Fujio (Japan)
Young-Keun Lee (Korea)
Wing Lim Tse (Hong Kong)
Abhijeet Wahegaonka (India)
James Siu Ho Wa (China)
Clara Wong (Hong Kong)

Sponsors



Program Outline

Approximate timings – subject to change.

Thursday 5th October 2017
1900-2230 Faculty Reception

Friday 6th October 2017
0800-1600 Cadaveric Workshop

Saturday 7th October 2017
0800-1600 Academic program and exhibition
1900-2300 Congress Dinner, Adelaide Oval

Sunday 8th October 2017
0800-1600 Academic program and exhibition
Dedicated Hand Therapy sessions

Submit Abstracts to APWA Website

<http://apwa.asia>

Follow submission
guidelines

Submissions close:

Mon 12th June 2017

Congress Secretariat



APWA 2017 Annual Congress
Secretariat

Lara Birchby, Meeting Manager
The Meeting People Pty Ltd
PO Box 764, MITCHAM South Australia
5062
Tel: +61 8 8177 2215
lara@themeetingpeople.com.au

Berlin Germany

Save the Date

20–24 May 2019

14th IFSSH
and
11th IFSHT
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2019



Building Bridges – Together Hand in Hand



Date

20–24 May 2019

Venue

CityCube Berlin, Germany
www.citycube-berlin.com

Congress Website

www.ifssh-ifsht2019.com

International Societies

International Federation of Societies for Surgery of the Hand (IFSSH)

www.ifssh.info

International Federation of Societies for Hand Therapy (IFSHT)

www.ifsht.org

Local Host Societies

German Society for Hand Surgery (DGH)

www.dg-h.de

German Society for Hand Therapy (DAH/TH)

www.dahth.de

Associated FESSH Congress

Federation of European Societies for Surgery of the Hand (FESSH)

www.fessh.com

Fiscal Organiser, Congress & Exhibition Management

Intercongress GmbH

Düsseldorfer Straße 101

40545 Düsseldorf, Germany

ifssh-ifsht@intercongress.de

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