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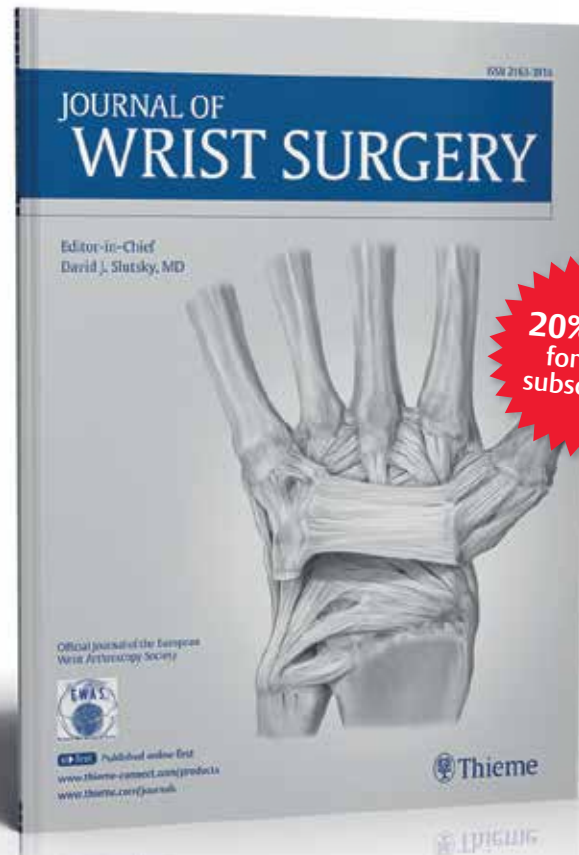


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FOLLOWING NERVE REPAIR IN CLINICAL
PRACTICE

IFSSH 50TH
ANNIVERSARY

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IFSSH 50th Anniversary

The need to manage upper limb injuries sustained during the Second World War and the advent of penicillin were two significant factors in the rapid progress of the development of hand surgery as a sub-speciality. Norman Kirk, the U.S. Surgeon General, invited the American surgeon Sterling Bunnell to establish nine centres devoted to hand and upper limb surgery throughout the United States during the Second World War.

Those associated with this endeavour created the American Society for Surgery of the Hand (ASSH) in 1946. Other countries followed. The International Federation of Societies for Surgery of the Hand (IFSSH) was founded in Chicago in 1966, 50 years ago. The original eight founding societies and their representative

delegates were A Bonola (Italy), T Morotomi (Japan), A Barsky (USA), G Stack (UK), N Carstam (Scandinavia-Sweden), D Buck-Gramcko (Germany), A Pernet (Brazil) and R Tubiana (France).

With Arthur Barsky presiding, other surgeons who joined the above named included the patron of the forthcoming IFSSH Congress in Buenos Aires, Argentina, Eduardo A. Zancolli, representing the South American countries, Millesi from Austria, Entin from Canada, Capner, Harrison and Patterson from Britain, Mallek and Michon from France, Mancini, Morelli and Operti from Italy, Saito from Japan, Isaakson and Skoog from Sweden, Verdan from Switzerland and Boyes, Curtis, Kaplan, Riordan, and Swanson from the United States. All played a major role in the IFSSH development.

From this small group of influential countries, the IFSSH has expanded to now encompass 56 member societies. These member societies include those from first world countries in which hand surgery has developed to a sophisticated level and those from countries of disparate socio-economic development and more recent establishment of hand surgery societies. All are equally

welcomed beneath the umbrella of the IFSSH. Our Charter is to coordinate the activities of the various societies for surgery of the hand throughout the world, and in this way to increase and spread knowledge of surgery of the hand. The chief purposes are listed as follows: (1) to coordinate the activities by maintaining liaison between the various societies, (2) to promote the

free and full exchange of knowledge among the constituent organizations, (3) to improve and widen the opportunities for study and observation of Hand Surgery in the various countries, (4) to establish and recommend the adoption of certain standards of nomenclature, classification, evaluation and treatment of hand pathology, (5) to promote access to the world literature on surgery of the hand, (6) to disseminate knowledge through publications and scientific meetings and to enhance the study and practice of surgery of the hand, (7) to improve the education and research in Hand Surgery at all professional levels, (8) to take an interest in the socio-economic impact of disorders of the hand, (9) to further the availability of Hand Surgery throughout the world, (10) to further the cooperation between hand surgeons and other related professionals,

(11) to encourage the cooperation of all members to advance the principles and practice of Hand Surgery of all members throughout the world through organized participation in all areas of the specialty.

It can be seen from these principles that many of these purposes relate to the support and development of hand surgery in underdeveloped countries. The IFSSH relies on its more affluent and sophisticated member societies in fulfilling this role. This intent is also reflected in the nature of the triennial IFSSH Congress in which an inclusive and non-judgemental environment is created with the common purpose of elevating the management of injury and disease affecting the hand and upper limb to the highest of possible standards. The opportunity to meet and mix with hand surgeons and therapists from throughout the globe remains one of the most valuable and endearing assets of the International Federation. We learn from each other, without assumption of superior knowledge and in spite of disparate life circumstances.

We honour those who have contributed to the international development of hand surgery. We delight in our association

with the International Federation of Societies for Hand Therapy (IFSHT) and other sub-speciality groups related to surgery of the hand and upper limb.

The Buenos Aires Congress is the first to be held in South America. The IFSSH Delegates' Council has created a geographic rotation which is aimed at a fair geographic distribution of triennial congresses. However, it can be seen that with 56 societies, a number of generations must pass before it is possible for all societies to have a chance to host a congress. There are many competing meetings, all valuable. As such, from time to time clashes in timing will occur. Goodwill should allow our hand surgery fraternity to manage these.

We look forward to celebrating the 50th anniversary of the IFSSH with you all in Buenos Aires.

Michael Tonkin
IFSSH President



Figure 1: Delegates at the founding meeting of the IFSSH in Chicago in 1966 (courtesy of Dr. Sergio Gama)

Spring in Buenos Aires!

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IFSSH 50th Anniversary



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IFSSH Newsletter

Dear friends:

If you are old enough, you'll probably remember a song called "I don't like Mondays" by the Irish band The Boomtown Rats. Written by Bob Geldof, it was an easy-going song that became one of the biggest British hits of 1979. I remember it well for, at that time, I was resident, and Mondays, particularly after being on call the entire weekend, were awful. "Neither do I" I thought every time I heard that song on the radio of my round-up Seat 600. "Neither do I" still is my automatic reaction when I get up early on a working Monday. And yet, there is always an exception confirming the rule: There is a forthcoming Monday that will not be that awful. I am thinking on this year October 24th.

To be honest, I must acknowledge that October 24th has never been a meaningless day in the past. On that day in 1857, a bunch of visionary football fans founded Sheffield F.C., the world's oldest football club. Also on that day, but in 1901, Mrs. Annie E Taylor was the first person to go over Niagara Falls in a barrel. On October 24th, 1926, the American illusionist and stunt performer Houdini offered his last escape act in Detroit. On October 24th, 1945, United Nations was founded. In 1964, Zambia

gained independence from British rule on that day. In 2003 on that day, Concorde, the British-French supersonic passenger jet, made its last commercial flight. On October 24th 2007, China launched the first spacecraft of its Lunar Exploration Program. Indeed, lots of outstanding events happened that day, and this year will not be an exception. At 6:00pm sharp, in the Pacifico room of the Hilton Hotel by the spectacular Puerto Madero of the beautiful city of Buenos Aires, our Federation will commence the celebration of its 50th Anniversary. It will commence with the Opening Ceremony of the XIIIth Congress of the International Federation of Societies for Surgery of the Hand and Xth Congress of the International Federation of Societies for Hand Therapy (see www.ifssh-ifsht2016.com) and I hope to see you all there.

If I had to summarize Buenos Aires in one single sentence I would not hesitate to declare it as an impossible-not-to-love city. And I mean it. I still remember the first time I visited the so-called "Big Apple" of the Southern Hemisphere. It was a cold summer in 1998, but it didn't take long for me to appreciate the warm nature of my Argentinean friends. Indeed, I very quickly realized that that city is indeed special. It's certainly

not the cleanest city on earth, nor can the traffic can be described as ordered and quiet, but Buenos Aires is adorable. There is no need to be possessed by the magic spell of an artisans market in San Telmo, or by the strong taste of a slowly cooked asado to love this city. You only need to listen to "Volver" by Carlos Gardel while wandering along the cobbled streets of the Caminito in good company and you'll be hooked forever.

Obviously, aside from a song, there are more reasons for the membership to consider attending our meeting. These include:

1) to acknowledge the key role played by eminent Argentina pioneers (Finnochietto, Otholengui, Cozzi, Zancolli,...) in the development of hand surgery as an important specialty.

2) to benefit from one of the most interesting scientific programs of our specialty, designed to please everyone, regardless the level of expertise or the area of individual interest.

3) to show our gratitude to the enormous work done by the local organizers of the IFSSH 2016 to meet the challenges of a meeting this size in a global, frantic, often disconcerting world.

4) to exchange information with those colleagues from all over the world that share your passion.

5) to enjoy the unique opportunity of extending the trip to visit first-class touristic attractions, such as Patagonia, one of the most beautiful regions of the world, or the most impressive Iguazu falls.

6) to get seduced by a brilliant Buenos Aires, a fascinating city that continuously reinvents itself, a city that makes no exceptions when it comes to integrate foreign cultural influences, a city that knows how to please visitors.

7) to celebrate the 50th anniversary of our Federation

8) to learn how to tango: one of the sexiest activities one can do while still standing upright

Let me also remind our society delegates that the IFSSH Delegates' Council Meeting will be held at 1pm, Thursday 27th October (Room Atlantico C, Hilton Hotel). An agenda and further information will be provided over the coming months. Please note that this meeting will involve voting procedures, including the selection of the 2022 IFSSH Congress host society. It is therefore important that your society is represented at this delegates' Council Meeting. If you (as the official society delegate) cannot attend, please request that a representative from your

society is present. As the meeting approaches, we will forward proxy forms for completion. Please also note that only one member of your society may vote and to do so your society must be in financial good standing with the IFSSH. If you have any queries about this process or about your financial position, please contact the secretariat (administration@ifssh.info).

Registration information, scientific and social programmes, and accommodation and tourism suggestions are available on the congress website: <http://www.ifssh-ifsht2016.com/>

I hope to see you in Buenos Aires in October.

Yours sincerely,

Marc Garcia-Elias
Secretary-General, IFSSH
Email: secretary@ifssh.info



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IFSSH Scientific Committee on Cerebral Palsy

Chair: Ann Van Heest (USA)

COMMITTEE: MARIANNE ARNER (SWEDEN), FRANCK FITOUSSI (FRANCE), MICHELLE JAMES (USA)

REPORT SUBMITTED NOVEMBER 2015

Treatment of the upper extremity manifestations of cerebral palsy continues to be a focus of ongoing research with over 150 articles published on this topic during 2014. Several recent advancements are highlighted for this committee's report.

Therapy Protocols

Whether insults to the CNS occur due to malformations, ischemia, or parenchymal lesions, therapy interventions continue to be

developed and refined based on the adaptive plasticity of the central nervous system (CNS). Constraint induced movement therapy (CIMT) and bimanual hand therapy are two examples.¹

Motion lab and biomechanics

Use of the motion lab to describe and further define the kinematics of the movement disorder continue to develop. The dynamic pattern of cerebral palsy upper limb motion is highly variable, mainly in relation

to the location and the extent of the central nervous system injury. Current clinical methods of upper limb evaluation are made in terms of function, motor control, sensory impairments, dexterity, tone, degree of fixed versus dynamic deformity, and passive and active range of motion. In the higher functioning child, the quality of upper limb movement during several functional tasks is quantified using available clinical scales. Classification using the

Manual Ability Classification System (MACS) evaluates the child's ability to handle objects in daily activities, and parallels the Gross Motor Function Classification System used for lower extremity assessment in cerebral palsy.

In order to better understand upper limb kinematic anomalies, several upper limb kinematic protocols have been developed. The linking of specific associated movements to a single joint deformity implies that treatment aiming at the correction of that single impairment will have an effect on all degrees of freedom involved in these associated movements.² The differentiations between a true impairment and a compensatory movement are, therefore, essential for the planning of treatment for multiple dynamic deformities. Associated compensatory movements should not be mistaken for separate impairments, as they do not need treatment. Dynamic trunk, shoulder or elbow kinematics anomalies in children with mild hemiplegia involvement could be related to a compensatory movement strategy. Indeed, in patients with lack of available ROM of the distal joints (the forearm and the wrist), additional degrees of freedom are integrated in the movement strategy in the proximal joints to perform the daily living tasks as described in hemiplegic adults. Proximal kinematic anomalies around the trunk, shoulder or elbow should therefore not be treated first

but should be reconsidered after treatment of forearm and wrist limitations.³

“In order to better understand upper limb kinematic anomalies, several upper limb kinematic protocols have been developed”

Biomechanical studies about in vivo wrist torque in hemiplegic patients showed that despite distal tenotomy, the wrist flexors muscles still contribute to the flexion torque at the wrist through myofascial force transmission.⁴ The therapeutic consequences are that when a surgeon performs a distal tenotomy, a release from the surrounding fascia of the involved muscle should always be associated for an optimal result. Dynamic EMG analysis coupled with video is still a useful tool

in order to characterize patterns of muscle spasticity for tendon transfer planning. A good voluntary phasic control makes a muscle a candidate for a tendon transfer.

Timing of treatments

Recent publications support early interventions. Hand function assessment in the first years of life, and its evolution over time, combined with neuroimaging and cortico-spinal projection patterns in children with unilateral cerebral palsy showed an improved prediction of prognosis in young children.⁵ Early treatments could shape future rehabilitative strategies based on the neurobiology and the therapy-induced changes seen in the brain.⁶ These studies suggest that the first 2 years of life are a critical period during which non-surgical interventions could be more effective than in later life.⁷ New evaluation tools of hand function in small children with CP, 8-18 months, have recently been introduced and may facilitate implementation of early interventions.^{8,9}

Surgical Treatment

Surgical treatment has been compared to botulinum toxin and regular ongoing therapy for children with spastic hemiplegic CP who are candidates for surgical intervention using a randomized surgical trial; surgery had greater improvements in functional use

related to better joint positioning (better wrist extension and forearm supination).¹⁰ Some authors have cautioned against doing tendon transfers in CP before adolescence because of the risk of overcorrection, especially at the wrist.¹¹ Spastic muscles, such as the Flexor Carpi Ulnaris, have been shown to have a reduced growth potential and may hence become tight when the child grows.¹² A wrist fixed in extension will limit the ability of releasing objects which may be very disabling. Lastly, the indications for surgical intervention have been evaluated, questioning whether bodily impairment measures such as active range of motion, or whether functional evaluations, are more appropriate.¹³

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Alfred B. Swanson, MD, FACS

16 April 1923 – 27 April 2016

It is probably fair to state that without the efforts of Al Swanson, the International Federation of Societies for Surgery of the Hand (IFSSH) would not exist. Dr. Swanson, who died at the age of 93 years on April 27, 2016, was not only one of the principal founders of the IFSSH, but because of his close relationship with many international colleagues and trainees and the respect they held for him, was the one driving force to the continued success of The Federation. Even though the IFSSH established its charter in 1966, the first Congress was not held until 1980 in Rotterdam and was organized by Al Swanson and Jacques van der Meulen of The Netherlands.

Dr. Swanson served as the Secretary General of the IFSSH from 1977-1980, and was the only President of seventeen to serve two terms. He then continued to serve the IFSSH as Historian from 1990-2003. Because of his dedicated leadership and many contributions to the IFSSH, a "Swanson Lectureship", the keynote address for the triennial Congress, was established in 2007 in his honor. He was also recognized by the Federation in 1995 as a Pioneer in Hand Surgery.

Al Swanson was born in Kenosha, Wisconsin on April 16, 1923. He received his undergraduate and medical school education at the University of Illinois, and his orthopaedic training at the Universities of Illinois, Northwestern, and Indiana. He became the Chief of Orthopaedic Surgery and Director of the Orthopaedic Surgery Residency of Blodgett Memorial Hospital in Grand Rapids, Michigan from 1954-1979. He also was the founding Director of the Orthopaedic Research and Hand Fellowship at Blodgett Hospital from 1962-2001. A consummate educator, he

trained 97 hand surgery fellows from 32 countries.

Dr. Swanson served as President of the American Society for Surgery and authored more than 300 scientific articles and one book. He was recognized for his treatment of children with congenital anomalies, poliomyelitis and cerebral palsy. He established practical and standard classifications for congenital limb anomalies as well as physical impairment ratings. Perhaps his greatest contribution was the development of silicone flexible implants for the small joints in the hands of arthritic patients. His silicone implants have served as the gold standard for more than 50 years as no other implants have been proven to outperform them in pain relief, function, and longevity. He was presented national humanitarian awards and recognized for his voluntary work in aiding and training hand surgeons and establishing polio vaccination programs in other countries such as Vietnam and Peru.

During his later years, he remained active by promoting environmental awareness, tree protection, and planting on a worldwide basis.

Al was always very proud of his family – his children Eric, Miles and Karin and their children. He was especially proud and appreciative of his wife, Dr. Genevieve de Groot Swanson, who together made a strong team, serving humanity in many different and long-lasting ways. A giant in our profession has fallen, but his significant contributions will carry us for many future decades..

James R. Urbaniak



Kenya Tsuge

25 November 1921 – 1 May 2016



Kenya Tsuge, emeritus professor at Hiroshima University and known as the "father of Japanese hand surgery," died on May 1, 2016 at Hiroshima University Hospital, his alma mater, following a fall from the stage just before his memorial lecture during the 59th

Annual Meeting of the Japanese Society for Surgery of the Hand (JSSH). He was 94 years old.

Professor Tsuge was a leader in hand surgery for almost 60 years, performing more than 10,000 operative cases from 1965 to 1985 during his career at Hiroshima University. More than 70 Japanese surgeons and 60 surgeons from overseas came to observe his surgeries. He always emphasized that his surgery was not only a function of logic but also a matter of surgical technique. His "Hiroshima Hand Course" was held for more than 10 years and trained more than 600 surgeons. He was also invited to speak as a guest lecturer all over the world.

His books, *A Principles and Practice of Hand Surgery* (1965) and *A Comprehensive Atlas of Hand Surgery* (1985) were popular not only in Japan but worldwide. His *Atlas of Hand Surgery* was translated into Chinese, English, German, Italian, and Korean, making it unique among medical books to be translated into so many languages. His many innovations for hand surgery included a procedure with looped nylon suture fitted with a needle.

Professor Tsuge was awarded the Kun Santo Order of the Rising Sun, Gold Rays with Neck Ribbon in 1996 and received the "Pioneer of Hand Surgery" award at the 1992 meeting of the International Federation of Societies for the Surgery of the Hand in Paris. He was one of the seven moderators at the first annual meeting at the JSSH in Kobe on July 7, 1975. Perhaps one of the most significant recognitions was the long and enthusiastic standing ovation he received after his lecture on the treatment of the Volkmann Contracture via video during his "Retrospective & Recollection" lecture at the 28th annual meeting of the ASSH in Las Vegas.

Given his dedication and exemplary contributions to hand surgery, it is in a way fitting that his life drew to a close on his way to give a lecture in his hometown of Hiroshima. We pray that his soul may rest in peace.

Moroe Beppu
Professor Emeritus,
St. Marianna University

Yoshikazu Ikuta
Professor Emeritus,
Hiroshima University



Tatsuya Tajima, MD, (1924 - 2003)



Tatsuya Tajima was born in Japan, 3 June 1923. He graduated from Niigata University School of Medicine in 1947. While he was training in orthopaedic surgery at the Albany Medical Center Hospital, New York, he became interested in hand surgery. Through the recommendation of Crawford J Campbell, he studied hand surgery with William Littler at Roosevelt Hospital in New York City in 1953 where he was the first Hand Fellow from Japan. He also trained with Joseph Boyes in Los Angeles in 1966.

Dr Tajima helped Professor T Amako, his former teacher, to establish the Japanese Society for Surgery of the Hand in 1957 which was the fourth such society

in the world. Prof Tajima was President of the Japanese Society for Surgery of the Hand (1971-1972) and has been national delegate to the International Federation of Societies for Surgery of the Hand since 1966 for many years. He served as President of the IFSSH in 1976-1977 and was Chairman of the Third International Congress held on the 3rd to 8th of November, 1986 in Tokyo. Prof. Tajima was Professor and Chief of the Orthopaedic Department of Niigata University from 1970-1989 and Director of the Niigata University Hospital from 1975-1979. He was President of the Japanese Orthopaedic Association (1986-1987) and the Japanese Plastic and Reconstructive Surgery Society (1972-1973). He became Honorary Fellow of the American Association for the Surgery of Trauma in 1976. He was Honorary Member of the American Association for Surgery of the Hand (1982), and of the British Society for Surgery of the Hand (1992), Corresponding Member of the German-speaking Society for Hand Surgery and Associate Editor of the American volume of the Journal of Hand Surgery.

Prof. Tajima has trained a large number of surgeons from Niigata and other Japanese universities as well as from foreign countries including Europe and China. He has published over 100 papers on hand surgery and contributed chapters on the hand and forearm in several major Japanese monographs on orthopaedic surgery and traumatology published in Japan. He was chief organizer of the Advanced Hand Surgery Course held every year in Niigata since 1974. Since his retirement from the Niigata University in 1989, he was Chairman of the Board of Directors of the Niigata Hand Surgery Foundation, Inc., where he consulted and performed surgery on hand surgery patients.

At the Sixth International Congress of the IFSSH held in Helsinki, Finland in 1995, Prof. Tatsuya Tajima was honoured as "Pioneer of Hand Surgery"

Christopher Berkeley Wynn Parry MBE, DM, FRCP, FRCS (1924-2015)

Christopher Berkeley Wynn Parry was born on 14 October 1924. Dr Wynn Parry is known worldwide for his expertise in rehabilitation. He was in the Royal Air Force Medical Branch from 1948 to 1975 becoming Consultant Adviser in Rheumatology and Rehabilitation for the Service during his last fifteen years. He developed the residential medical rehabilitation units at Chessington and Headley Court expanding their activities to embrace orthopaedic conditions and also complex rheumatological and neurological problems. He developed a rehabilitation service for the severely injured hand with particular emphasis on peripheral nerve and brachial plexus lesions. His contributions included the use of serial plasters following intensive physiotherapy for stiff hands and fingers, the use of lively splints, the development of sensory re-education and the management of causalgia and reflex sympathetic dystrophy. An important step was the resettlement of the severely injured to gainful employment. These experiences were reported in his book "rehabilitation of the Hand", which was first published in 1958. The fourth edition, published in 1982, indicated its great popularity. This first book

devoted to this important subject stimulated the development of rehabilitation services for the hand and upper limb in a number of countries.

On leaving the Royal Air Force in 1975, Kit Wynn Parry became Director of Rehabilitation at the Royal National Orthopaedic Hospital, where he developed a unit for assessment and rehabilitation of locomotor disorders with particular emphasis to head injuries, brachial plexus and peripheral nerve injuries. He specialized in the development of electromyography for assessment of peripheral nerve problems and in the use of sensory-evoked potentials. He became particularly interested in the management of intractable pain and his profound experience was demonstrated by his editorship of a book on the subject published by Churchill Livingstone.

Dr Wynn Parry is a Past-President of the British Society for Surgery of the Hand, an unusual honour for a physician. He was National Adviser on Rehabilitation to the National Health Service for many years and has served on many committees and societies.



In addition to the books he has written, he contributed over fifty publications and twenty-five book chapters on such subjects as pharmacology, electro-diagnosis, rehabilitation and resettlement, rheumatology, management of pain, peripheral nerve disorders, brachial plexus lesions and sports injuries. Dr Wynn Parry has played a major role in developing specialized units for the assessment, management and resettlement of patients with severe injuries and diseases of the upper limb and hand.

Kit Wynn Parry was honoured as "Pioneer of Hand Surgery" at the 6th International Congress of the IFSSH in Helsinki, Finland in 1995.

The International Federation Archives

The recent work on our archived material was started by my predecessor Bill Cooney. Archive material is of little benefit unless it can be easily accessed. This poses very significant problems for an organisation with worldwide responsibilities. In the past the executive committee spent some time considering which institution should be chosen to house its bundle of documents and files and how they might be classified. The Kleinert Institute in Louisville was one suggestion or possibly archived in Lausanne in Switzerland. Whatever site was chosen would inevitably mean a limited number of local people would have excellent access, but virtually nobody else.

The Internet has changed all of that; if all the documents were scanned they could be made available to all members of the Federation wherever they might live. We therefore moved forward with a plan to archive virtually all of our documents on the Internet.

Retrospective action

As is so often the case I feel we developed an interest in this rather too late in the day. The archivist of the Federation had some documents passed on from previous holders of the office, but it was only very partial and incomplete. Bill Cooney sent me some material, but had other documents scanned in America. The American Society for Surgery of the Hand were engaged in a similar exercise and kindly supported our efforts. I refined the documents that had been sent to me and they were also scanned in Derby. I checked through all Guy Pulvertaft's documents – he was an archivist's dream, on occasions hoarding train tickets and other documents of limited interest. Bill and I also liaised with Al, and more recently Geneviève, Swanson for additional data and also with Eduardo Zancolli senior. Mail shots to the

International membership regrettably did not lead to additional material. If the exercise had been performed 10-15 years earlier perhaps we would have got a more complete retrospective collection.

The most important documents were, we felt, the Executive Committee minutes, and then more recently the minutes of the Delegates meetings. Over and above that crucial data we also archived the programmes of the International Federation Congresses, the Pioneer booklets and searched for the original Charter. We also archived all the alterations to the Charter, as the years have progressed.

I had a hard copy of the original minutes of the Executive Committee dated the 20 January 1966 (Dr Arthur Barsky presiding). Regrettably we had no minutes from 1966 until the 6 March 1971 and then no minutes until the 24 February 1981. We have no Ex-Co minutes from 1982-86 or 1987-2000. If any member has a copy of those we would be grateful if you would scan them and send them to Belinda in the Secretariat (email administration@IFSSH.info) . We have all the data we require from 2000 onwards as it was stored in electronic format from inception.

The Delegates Council Minutes

I am not certain when minutes were first taken, perhaps in Barcelona in the year 2000. Our first minutes for the Delegates are from 2001 and we have a complete collection thereafter.

The Pioneer Booklets

We have done better with these having, I believe, the complete collection (some of the earlier ones being a

supplement of the American Hand Surgery Journal).

The Inaugural Charter

This object is gradually taking on the character of the Holy Grail or possibly a unicorn; does it still exist or has Voldemort stolen it with the awesome power it possesses. If Harry Potter could find it I would be grateful.

General Correspondence

I trawled through hundreds of letters and documents, scanning those I thought might be of interest to people in the future.

From the Millennium onwards

We have virtually everything relevant to the development and progression of the Federation from that time onwards.

The Archive

The first part relates to the Federation Protocol Book. This covers all the Federation's working documents which include;

- Contact details
- Bylaws
- Current Charter
- Congress Guidelines and venue rotation
- Congress contracts
- Committee of educational sponsorship criteria
- Harold Kleinert Visiting Professorship criteria
- Pioneers of Hand Surgery criteria
- Swanson Lecturer criteria
- Scientific Committees
- Secretary General duties
- Society contact detail forms and documents related to annual dues

The index then covers the following subjects:

1. Charter updates and when they occurred
2. Executive Committee minutes
3. The Delegate Council minutes
4. Financial matters and Treasurers reports
5. Educational sponsorships
6. Scientific Committee reports
7. Triennial congresses

8. Pioneers in Hand Surgery and their CV's
9. The history of the International Federation
10. The history of National Hand Societies
11. General correspondence – this is classified by year with any document considered to be of interest available to be seen.
12. There are also categories of Other (2007-2010 and 2010-2013). These are areas for previous officers to provide documents that they feel were of interest during their tenure.

Artefacts that are not being stored electronically

At present we have identified only three, which would be retained by the archivist during their tenure.

The original 1966 minutes – I have this document currently

The Federation Publication 'Hand Surgery Worldwide' – I also have this document currently

The original Federation Charter – at present missing, but perhaps it will be found

I step down as Archivist in Argentina in October. You are always hopeful that additional retrospective data will become available, but I suspect we cannot expect too much more. If the Officers of the Federation add data prospectively I think the archive will be a valuable resource for future members and archivists.

It's always helpful to know where you came from....

Frank Burke

Archivist IFSSH



Timing of sensory re-learning following nerve repair in clinical practice



Birgitta Rosen



Pernilla Vikström

Nerve repair and plasticity Phase 1 and 2

The function of the hand depends on the delicate interaction between motor control and sensory feedback. Following a nerve injury, a cascade of events occur in the peripheral and central nervous system. Directly after the injury no nerve signals are sent to the brain resulting in rapid changes in somatosensory areas and in the motor network in the brain where neurons usually serving the injured nerve start serving other functions. Gradually the injured nerve regenerates, although there is always a substantial misdirection of the regenerating axons resulting in a changed re-innervation of sensory receptors (the hand speaks "a new language" to the brain) and muscles.

Techniques to improve sensory recovery through early sensory re-learning with the use of sensory re-education techniques were introduced in the 70s. Due to the advances made in neuroscience during the last decades these re-learning programs have been modified. The purpose of sensory re-learning is to teach the patient to understand the new nerve signals ('language') from the hand. Without sensory re-education, patients can experience touch as unpleasant and they often cannot distinguish or identify through touch. In the period directly after surgery, phase 1, before regenerating axons have reached the hand, sensory re-learning is combined with training of the mobility of the hand. The purpose in this phase is to stimulate the neurons that used to be activated by the injured nerve and to maintaining the cerebral representation of the injured area thus preparing the brain for phase 2.

Phase 2 starts when the new axons have reached their end-organs in the skin or their muscles. Due to the misdirection of regenerating axons the normal order, somatotopy, in the primary somatosensory cortex is changed to a more

disorderly pattern and the sensibility during this time is not very useful.

Sensory re-learning model: Phase 1

Imagery exercises – think about touch

'Close your eyes and imagine the feeling of touching



something you like'; eg. stroking your dog, the feeling of holding your golf club, the feeling of grass or sand on the beach, etc.....". If the patient has difficulties doing this, actual pictures can help them imagine.

Observation exercises – observe touch

1) By touching the areas in the hand that have no sensibility and at the same time watch the touching, the neurons in the primary somatosensory cortex responsible for processing sensory stimuli from the hand can be activated. The patient can touch the fingers without sensibility himself by using the corresponding fingers of the other hand.



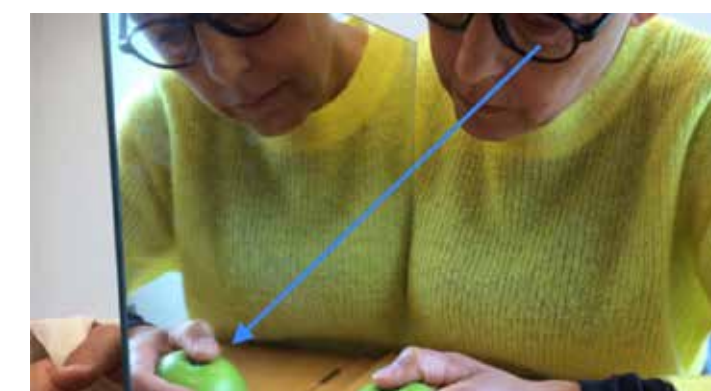
Someone else can also touch the fingers without sensibility and at the same time touch corresponding fingers on the healthy hand while the patient watches



carefully

2) When the patient observes someone else touch different things, they should think about how such touch normally feels.

3) Another method is mirror-visual feedback (MVF). A mirror is positioned so the patient can not see the injured hand but instead sees the reflexion of the unaffected hand on the place where the injured hand



should be. In this way an illusion of touch and activity can be created which can activate the correct cerebral areas of the injured hand and thus help to preserve the cortical image of the hand.

Substitution of senses exercises – encouraged to use all senses

1) All our senses cooperate when we touch something, so there are reasons to believe that activities that use other senses as well as bilateral activities can help to strengthen the touch function. The use of vision

to guide the re-training of sensation is the basis for classic sensory re-education, but there is a continuous interaction between all senses. Furthermore, there is a multi- and cross modal activity of the brain based on multisensory neurons that extract information from one sensory modality and use it in another sense.



The patient should be encouraged to use all senses to strengthen the feeling of touch. For example, “when you eat fruit think not only about its taste, but also the smell, colour and how the structure feels”.

2) Another way to achieve such an interaction between senses, demonstrated to have good effect in a randomised controlled trial, is the Sensory Glove System (SGS), which induces an audio-tactile interaction. The system transfers the sound of friction from textures being touched via microphones attached to the fingertips and headphones, thus providing the sensory cortex with an alternative sensory input at a time when regenerated nerve fibres have not yet reached the peripheral targets. Here the SGS-principle is illustrated with a “low-tech” version without electronics to amplify the sound.

Sensory re-learning model: Phase 2

The classic training technique described by Wynn-Parry and Dellon is used. This technique is based on stimulation with varying and increasing difficulty with the eyes open and closed alternated. In this way another sense, in this case vision, assists the

training. Exercises that integrate both sensory and motor training are highly recommended. Desensitisation, pain management, advice about cold sensitivity, strengthening and prehensile exercises to enhance the motor re-learning aiming at work-oriented rehabilitation is a vital part of phase 2. If hyperaesthesia/allodynia is present desensitisation exercises should precede sensory re-education. The dynamic capacity of the brain, ie plasticity, can be guided to improve functions that have been damaged or lost. This guided plasticity is believed to enhance the effect of phase 2 training. One example of guided plasticity is temporary cutaneous anaesthesia where an anaesthetic cream is applied to the volar parts of the forearm proximal to the injury. The neurons in the primary somatosensory cortex that usually process sensory information from the forearm then start processing sensory information from the hand, thus more neurons are available for processing sensory information, which results in improved sensory function in the hand. This concept together with intensive sensory retraining has been shown to improve sensibility in the hand in patients with median nerve injuries and also in patients with vibration induced neuropathy. The treatment needs to be done under careful supervision at the hospital and after prior testing to ensure that the patient has no history of adverse reactions to local analgesia.



Localisation exercises

Mislocalisation of touch after nerve repair can be a part of the difficulty when identifying objects without vision (poor tactile gnosis). The points stimulated on the skin no longer match with their central projection and the patient cannot interpret the changed sensation into a meaningful whole. Localisation exercises is a starting point in Phase 2.

Identification exercises

When capability to localize touch has improved (good localisation at fingertip level), touching and exploration of objects of various sizes, shapes and textures are begun. The therapist introduces exercises at the right level of difficulty based on sensory assessment. A variety of everyday objects as well as specifically designed products can be used for this, but it is recommended to use real and familiar objects. That makes it easier for the patient to incorporate the sensory re-learning into daily activities, which is of the utmost importance. The patient should be encouraged to carry a few objects in their pocket and try to identify them (e.g coins, keys) – and think about their shape, texture, and weight.



Bilateral tactile stimulation can help to positively stimulate the sensory and motor re-learning.

Education of the patient for adherence

Of importance during the rehabilitation process is to educate the patient about the injury and the importance of the interaction between the hand and the brain

in the rehabilitation process. The patient should also be aware that some painful symptoms, such as hyperaesthesia, are natural, and often increase during active regeneration periods. Due to the normal cortical reorganisation process, there will be a ‘new’ sensibility that has to be learned. It is also important to highlight that the re-learning is a long process. Regeneration, reinnervation and maturation of the growing structures take long time, and improvements of muscle function and tactile gnosis continue over years, depending on the level and severity of the injury.

A patient with knowledge and understanding of the consequences of a nerve injury is more likely to engage with their rehabilitation regimen and adhere to the necessary training. This will also allow the patient to find their own strategies to cope with pain and discomfort. An example of a patient information brochure can be found on: www.med.lu.se/klinvetmalmo/hand_surgery/clinical_projects/enhanced_sensory_relearning.

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Member Society Updates

AUSTRALIAN HAND SURGERY SOCIETY

The Australian Hand Surgery Society has had a busy 12 months. For many years we have been working steadily on increasing the profile of hand surgery in Australia and in the training of younger surgeons interested in a career in Hand Surgery. With the ever diminishing opportunities for our trainees to gain appropriate experience in Hand Surgery in overseas posts, our society under the guidance of Michael Tonkin and with the assistance of the Royal Australian College of Surgeons has established a Post Fellowship Education and Training (PFET) Program in Hand Surgery. Our first candidate successfully completed the program early this year. We now have 10 accredited hospitals and 17 trainees.

Along with this development we have witnessed an increased interest in Hand Surgery in the wider community with an ever increasing number of young and enthusiastic members of our society. The AHSS is now coordinating the hand surgery component of the annual scientific meetings of the Australian Orthopaedic Association and the Royal Australian College of Surgeons as well as our own Annual Scientific Meeting

After a very successful combined AHSS and ASSH meeting in Hawaii in 2012 the Australian Hand Surgery Society was invited back to San Francisco in 2013. We were able to return the complement and invite the ASSH to Australia for a further combined AHSS / ASSH meeting in Sydney in March this year. The meeting was very well attended with a total of 336 delegates from Australia, USA and 17 other countries from around the world. We were treated to a number of free papers, instructional courses and symposia that were exceptional and very well received. We were honored

to have L. Scott Levin from USA present our biennial Bernard O'Brien Oration.

The Inaugural meeting of the APFSSH was held in Perth, Australia in 1997. The Federation has subsequently expanded in membership and has held 10 further meetings since then. Australia has been appointed to host the 12th APFSSH meeting in Melbourne in 2020.

We are looking forward to the IFSSH meeting in Buenos Aires later this year and I am sure there will be a very successful meeting.

Anthony Berger
President AHSS



The ASSH/AHSS “Smack Down” tradition continued with the Aussie Lads and the victorious All American Sheroes debating clinical cases.

David Stabler (Immediate Past President, AHSS) with Scott Levin (USA), the Bernard O'Brien Orator



BELGIAN HAND GROUP

The activity of the Belgian Hand Group (BGH) has been quite loaded this year:

Past events:

- Belgian Hand group meeting during SORBCOT congress (Orthopaedica Belgica) - 28/04/2016 Knokke.
- Spring Meeting Belgian Hand Group and Belgian Orthopaedic Trauma Association (BOTA) - 05/03/2016 Gent.
- Cadaver Surgery Course Belgian Hand Group with BELSS and VVOV - 23/10/2015 Antwerp.
- BAPRAS & RBSPS Summer Meeting 2015 - 25/06/2015 Bruges.
- Belgian Hand group meeting during SORBCOT congress (Orthopaedica Belgica) - 22/04/2015 Louvain La Neuve.

Future events:

- 50th Annual Congress of the Swiss Society for Surgery of the Hand with the Swiss Society for Rehabilitation of the Hand and the Belgian Hand Group as invited Society - 24/11/2016 Genève.
- Cadaver Surgery Course Belgian Hand Group with BELSS and VVOV - 17-18/02/2017 Antwerp (Dr F.Verstreken).
- Congress of the Irish Society for Surgery of the Hand and the Belgian Hand Group as invited Society - 10-11/03/2017 Dublin (Pr. L.Van Overstraeten and Dr C.Bossut).
- AO hand surgery course - 23-24/03/2017 Charleroi (Dr B.Lefevre).

New election and switch of the board of the Belgian Hand Group:

President Elected: Luc van Overstraeten

Past president: Nadine Hollevoet

Vice President: Frederick Verstreken



The IFSSH Nominating Committee has recommended that Dr **Pierre Van Wetter**, who has contributed so much to hand surgery in Belgium, to be honoured with the award of **IFSSH Pioneer of Hand**, the first in Belgium



Finally, Belgium applies to be host country for the **IFSSH Congress in 2022** under Pr Jean Goubeau's presidency. The project could be a joint **IFSSH and FESSH Congress in Brussels**.

BRAZILIAN SOCIETY FOR SURGERY OF THE HAND

(Sociedade Brasileira de Cirurgia da Mão - SBCM)

The Brazilian Society for Surgery of the Hand (Sociedade Brasileira de Cirurgia da Mão - SBCM) was established by a group of surgeons many years ago. They planned a meeting to continue the exchange of information and explore how best to care for injuries and conditions of the complicated and delicate hand. SBCM continues to host its Annual Meeting to foster the exchange of ideas; SBCM also hosts several courses and learning opportunities each year.

The 36th Brazilian Congress of Hand Surgery was performed in the city of São Paulo. The seven hundred congress participants had the opportunity to discuss the injuries in the upper limbs during the practice of Olympic Sports.



Our next congress will be in Belo Horizonte. The official topics are: nerve, carpus, elbow and WALANT surgery
Dr. Carlos Henrique Fernandes
Vice-President, Brazilian Society of Hand Surgery



CHILEAN SOCIETY OF HAND AND MICROSURGERY

Chile, with an estimated population of 18 million stretches over 4,300 km (2,700 mi) along the southwestern coast of South America - a distance roughly the same as that from San Francisco to New York, or Edinburgh to Baghdad - and is one of South America's most stable and prosperous nations.

The Chilean Society of Hand and Microsurgery grew up under the tutelage of the Chilean Orthopaedic Society since its founding and we share an annual scientific meeting each spring, at different places around the country. Our neighbouring partners, the Argentinian and Brazilian Hand Societies, have been great inspirations in helping the Chilean Society reach our goals and we are proud to share with them a common view and process of development.

Our Society, with an estimate of no more than 50 full trained hand surgeons in the country, has worked primarily in continuing medical education programs to improve technical skills of their members, providing training in some areas such as soft tissue coverage and wrist arthroscopy. Our commitment with Chilean people is to give them excellence of care, even in the most distant areas of our exceptionally long country, and this focus guides us to privilege training of young colleagues coming from distant areas, away from the capital city, Santiago.

We are proud to be one of the most enthusiastic groups of orthopaedic surgeons and expect that this generation will make a change in the standard of care of hand related problems in our country. Our development has been in parallel with the Chilean hand therapy group who have been recently accepted as a full member of the International Federation of Societies of Hand Therapy (IFSHT).

We look forward to joining with our colleagues from around the world at the next IFSSH meeting in Buenos Aires, Argentina

Javier Roman, President of Chilean Society of Hand and Microsurgery

Lorena Parra, Secretary of Chilean Society of Hand and Microsurgery



SPOTLIGHT ON IFSHT MEMBER SOCIETY: DENMARK

Established in 1987, The Danish Society of Hand Therapy (DSF Hand Therapy) has 238 members who are predominantly occupational therapists working in public healthcare settings. DSF Hand Therapy meets twice each year, often inviting international keynote speakers. Ingvild Kerken, professor in OT, will speak at the autumn meeting about arthritis. Each spring meeting is combined with the Danish hand surgeons. DSF Hand Therapy also sponsors courses with two fully booked recent courses on "Joint and Soft Tissue Mobilisation of the Hand" taught by Sarah Mee and Elaine Juzl from England.



Helle Puggård, Vice President; Kacia Ardensø, President; Mette Kudsk Olsen, Secretary; Kim Gotfred-Iversen, Webmaster; Peter Skødt, Treasurer; Gry Holten, Alternate; Anja Skriver, Newsletter/Commercial Members; & Hele Kissow, Alternate

IFSSH EZINE

The IFSHT contribution to the May IFSSH Ezine by Dr. Abby M Paterson, Ella Donnison and Prof. Richard J Bibb (<http://www.ifssh.info/ezine.html>) discusses 3D printing of customized wrist splints.



3-D printed wrist splint

IFSHT is keen to have clinically relevant articles for the IFSSH Ezine. Please contact presidentelect@IFSHT.org.

2016 IFSSH/IFSHT CONGRESS

The upcoming 2016 IFSHT Congress received a record number of abstracts! The diverse program in Buenos Aires includes 78 invited presentations, 50 free papers and 37 posters, offering many opportunities to share and gain new knowledge. We hope you are planning to join us! IFSHT received many requests for support to attend



the congress due in part to the congress registration fee being equivalent to nearly a month's wages in South America. Regrettably, IFSHT funding is very limited and many requests could not be funded. If you would like to support the attendance of a therapist at the IFSHT Congress, make a donation to the IFSHT Travel Grant Fund or Evelyn Mackin



Evelyn Mackin at the Silent Auction in New Delhi, India

Award on the IFSHT website.

IFSHT will hold its triennial silent auction in Buenos Aires where donations of small, easily transportable items are needed. For those not attending the congress, please contact your country's IFSHT delegate to discuss transportation of donation items to the Congress. Delegate contact information can be found on the IFSHT website, along with the donation form. If you are willing to help with the auction in Buenos Aires, please contact auction chair, Sandra Frigeri at sanfrigeri28@gmail.com. It is a wonderful opportunity to meet other therapists.

2016 SCANDINAVIAN CONFERENCE

Therapists and surgeons met at the Scandinavian Society for Surgery of the Hand congress in Levi, Finland in April 2016. Two hundred fifteen participants from 18 different countries attended this Lapland venue. The therapists' program offered a deeper look at compression neuropathies, pain treatment approaches, and the tetraplegic hand, while the gala dinner featured reindeer fillet.



Saara Raatikainen (L), Congress Chairperson, & Sarah Ewald, IFSHT President

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

Tips & Techniques Proximal Row Carpectomy



Proximal row carpectomy is a relatively straightforward procedure but manipulating the proximal carpal bones during excision can be challenging. Some recommend using large Kirschner wires as "joy sticks" to help manipulate the individual carpal bones during excision. K-wires unfortunately frequently pull out of the carpal bone during manipulation and of course there is always the risk the K-wire will injure the surgeon and assistants. I have found using a 3.5mm tap allows the surgeon to securely manipulate the carpal bones during excision. (This is not an original idea.) The "technique" includes drilling a 2.5

mm hole in the carpal bone being excised followed by insertion of the tap. The tap handle allows comfortable well-controlled manipulation of the carpal bone during excision. The tap also eliminates the danger of the surgical team being impaled on the K-wire. One technical point is to be sure to place the tap in the center of the bone and remember to not advance the tap into the volar soft tissues.

Protecting the volar carpal ligaments during excision of the proximal carpal row is very important. It is often difficult to place a #15 blade parallel to the volar surface of the carpal bones during the liberation of the carpal bones from the volar ligaments. "Cleft palate" blades (Beaver® mini-blades #6910 or #6600) are ideally suited to address this issue.

The blade's 60° bend allows the

surgeon to pass the blade parallel to the volar aspect of the carpal bones thus permitting the surgeon to "peel" the volar ligaments off the carpal bones without transecting the longitudinal fibers of the extrinsic volar carpal ligaments.

I hope these two "pearls" will prove helpful to our colleagues.

Dan Nagle (USA)



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Amy M. Moore Susan E. Mackinnon

● Nerve Regeneration
Tessa Gordon

● Nerve Repair and Nerve Grafting
Samir K. Trehan,
Zina Model,
Steve K. Lee

● Autograft Substitutes
Bauback Safa,
Gregory Buncke

● Donor Distal, Recipient Proximal and Other Personal Perspectives on Nerve Transfers
Susan E. Mackinnon

● Nerve Transfers to Restore Shoulder Function
Somsak Leechavengvongs,
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● Nerve Transfers to Restore Elbow Function
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● Nerve Transfers in Birth Related Brachial Plexus Injuries
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● Nerve Transfers for the Restoration of Wrist, Finger, and Thumb Extension After High Radial Nerve Injury
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● High Median Nerve Injury
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● High Ulnar Nerve Injuries
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● Nerve Transfers in Tetraplegia
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● Free Functional Muscle Transfers to Restore Upper Extremity Function
Emily M. Krauss,
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● Management of Pain in Complex Nerve Injuries
Gabrielle Davis,
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● Donor Activation Focused Rehabilitation Approach
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Grey Giddins

● One-year results of needle fasciotomy and collagenase injection in treatment of Dupuytren's contracture: A two-centre prospective randomized clinical trial
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● New insights into the immediate outcome of collagenase injections for Dupuytren's contracture
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● Skin involvement in Dupuytren's disease
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● Skin involvement in Dupuytren's disease
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● The quantitative role of flexor sheath incision in correcting Dupuytren proximal interphalangeal joint contractures
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● Evaluation of vitamin D levels in women with carpal tunnel syndrome
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● Topographic matching of distal radius and proximal fibula articular surface for distal radius osteoarticular reconstruction
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● A single injection of collagenase clostridium histolyticum for the treatment of moderate Dupuytren's contracture: a 2 year follow-up of 47 patients
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● Collagenase induced syndactyly: a case report
G. Cheung,
T. Gajic,

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● Wade R, Igali L and Figus A. Skin involvement in Dupuytren's disease. J Hand Surg Eur. 2016, 41: 600–8.
Y. Oskrochi,
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● Dupuytren's Contracture. The Safety and Efficacy of Collagenase Treatment

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- A structured literature synthesis of wrist outcome measures: An evidence-based approach to determine use among common wrist diagnoses
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- The ulnar side of the wrist: Clinically relevant anatomy and biomechanics
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- Clinical manual assessment of the wrist
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- Epidemiology of distal radius fractures and factors predicting risk and prognosis
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- Rehabilitation for scapholunate injury: Application of scientific and clinical evidence to practice
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- Rehabilitation strategies for wrist sensorimotor control impairment: From theory to practice

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- Role of muscles in the stabilization of ligament-deficient wrists
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- Dart-throwing motion with a twist orthoses: Design, fabrication, and clinical tips
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- Taping techniques for the wrist
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- Long-Term Outcomes of Radial Osteotomy for the Treatment of Kienböck Disease
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- Vascularized Bone Grafts from the Dorsal Wrist for the Treatment of Kienböck Disease
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● Extensor Pollicis Longus Rupture after Mini TightRope Suspensionplasty

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● Distal Radius Isoelastic Resurfacing Prosthesis: A Preliminary Report

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Yao, Jeffrey; Zlotolow, Dan A.; Lee, Steve K.

2016

Hong Kong International Wrist Arthroscopy Workshop and Seminar

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10 Dec 2016 (Sat)

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Symposium and Clinical Workshop

慢性腕桡侧疼痛:专题讨论会及临床工作坊

Target Participant 参加对象:

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腕关节镜操作班

Intermediate and Advanced Course

中级课程及高级课程

Target Participant 参加对象: Orthopaedic Surgeon & Hand Surgeon 骨科医生及手外科医生

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International Faculty 海外受邀讲者:

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- Wei-jen CHEN (Taiwan 台湾)
- Keiji FUJIO (Japan 日本)
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Asia Pacific Wrist Association (APWA)
亚太腕关节医学会
Hong Kong Society for Surgery of the Hand (HKSSH)
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European Wrist Arthroscopy Society

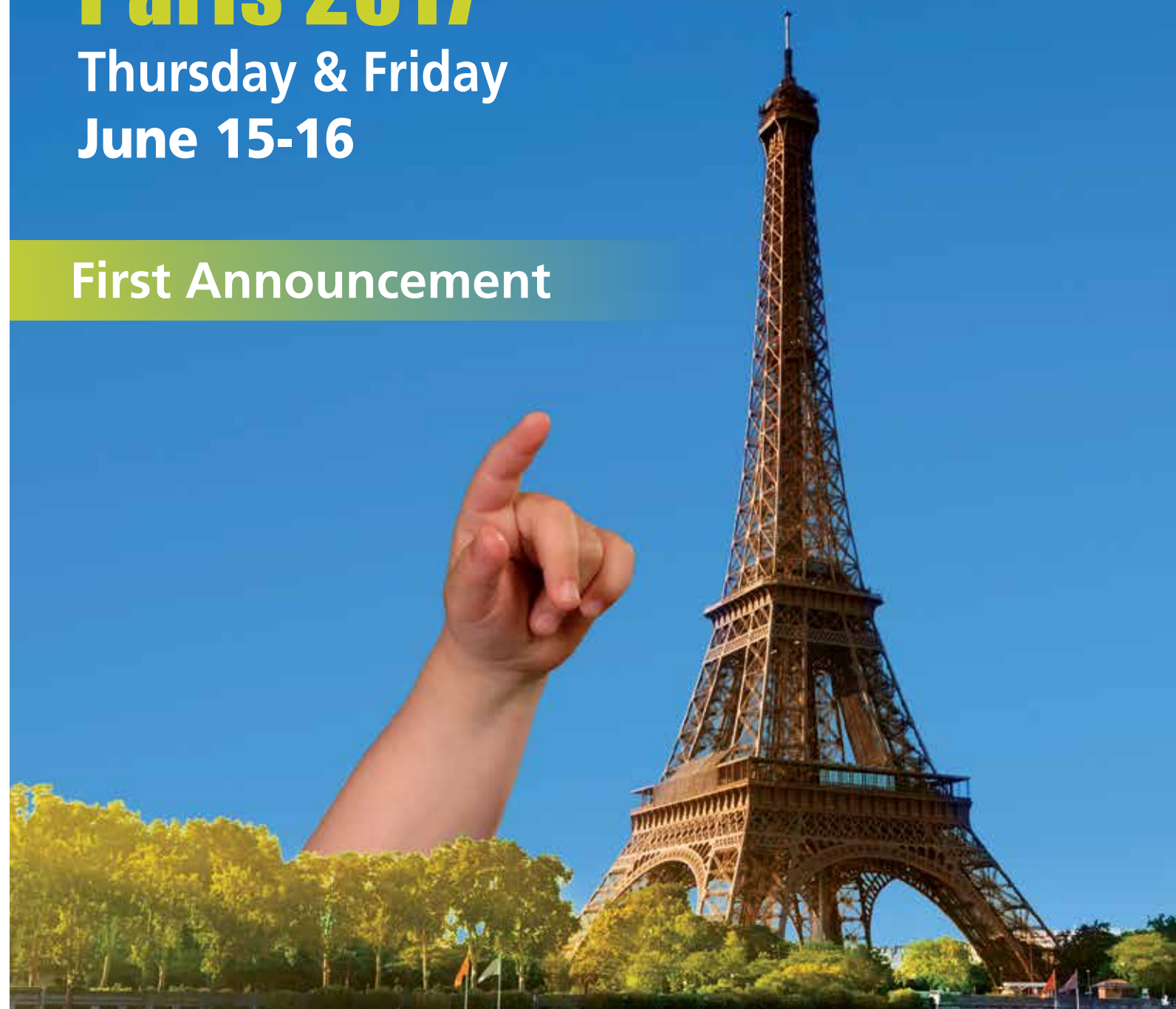


4th European Symposium on Pediatric Hand Surgery and Rehabilitation

Paris 2017

Thursday & Friday
June 15-16

First Announcement



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Dear friends,

I will have the honour of chairing the French Society for Surgery of the Hand in 2016.

During my medical training I was fortunate enough to have some very exceptional surgeons as masters who guided me and gave me the opportunity to develop my skills in scientific expression, research and teaching. This is why, to pay tribute to my masters I have decided to hand over our 2016 congress as a « gift » to our youngest members. Our congress is called « The New Wave ». I have invited some foreign lecturers who seem to remain eternally young! Marc Garcia-Elias, Diego Fernandez, Francisco Del Pinal and Gustavo Mantovani. Traditionally we also invite a « non-surgeon ». I have asked my good friend Gaël Chauvet, a great sommelier, who has selected the wines at the prestigious Lavinia winery since it was created and who is friendly with all the best wine-growers to give us a lecture on « The hand of the wine-grower »... I'd be prepared to bet that there will be more wines and wine-makers than hands...

Everything is ready to make our 2016 congress a successful one!

I hope you will all be there!

Christophe Mathoulin
President SFCM 2016

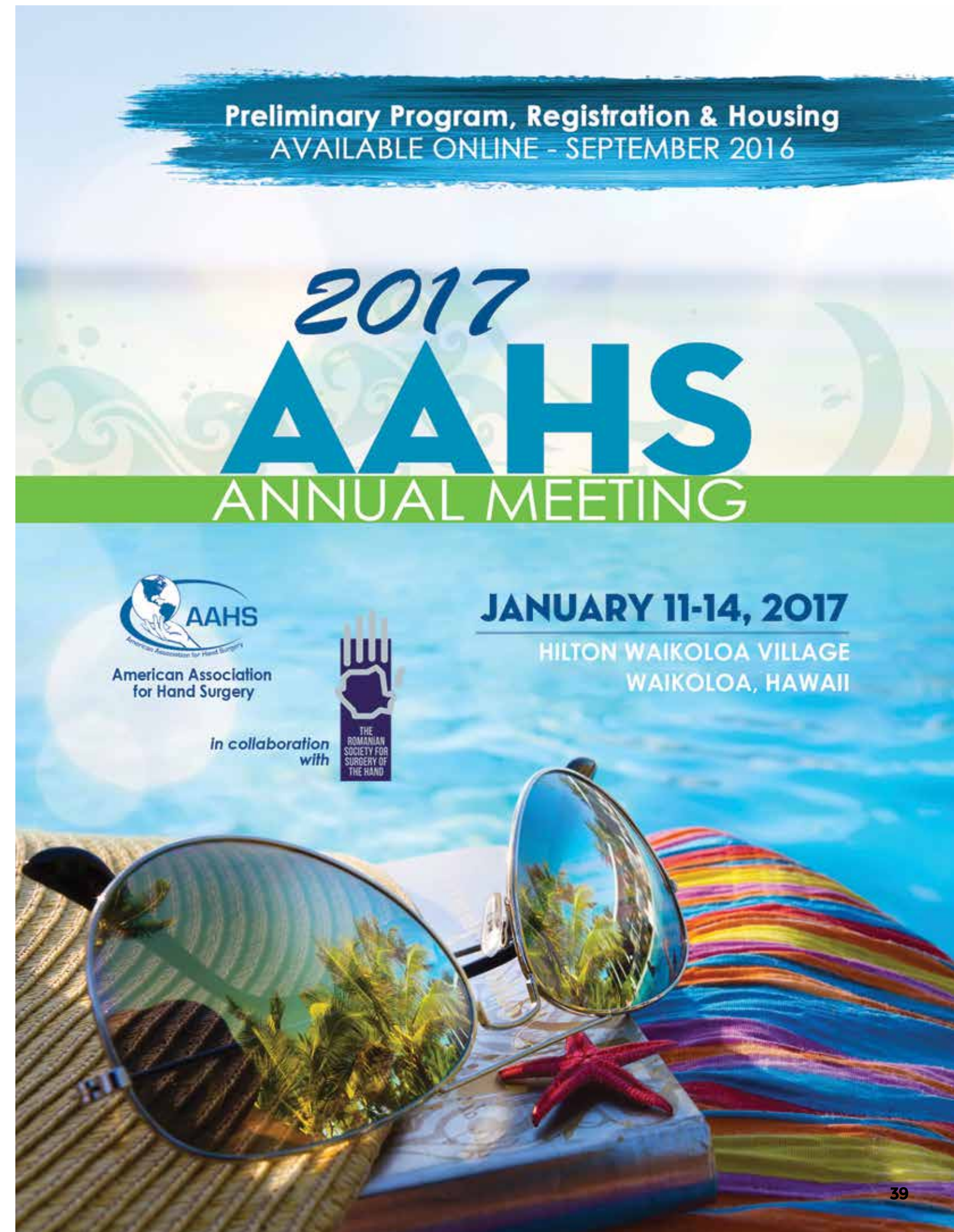
ALL HANDS ON DECK

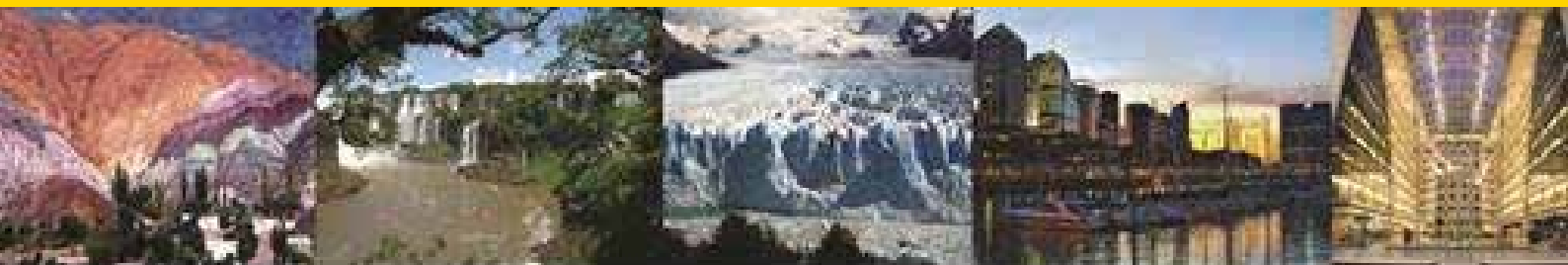
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