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CONNECTING OUR GLOBAL HAND SURGERY FAMILY

SPECIAL FEATURE:
25 YEARS - LESSONS LEARNT
TIPS AND TECHNIQUE:
INJURED HAND
IFSSH SPONSORSHIP:
WORKSHOP



Scientific Committee Report Rheumatoid ARTHRITIS

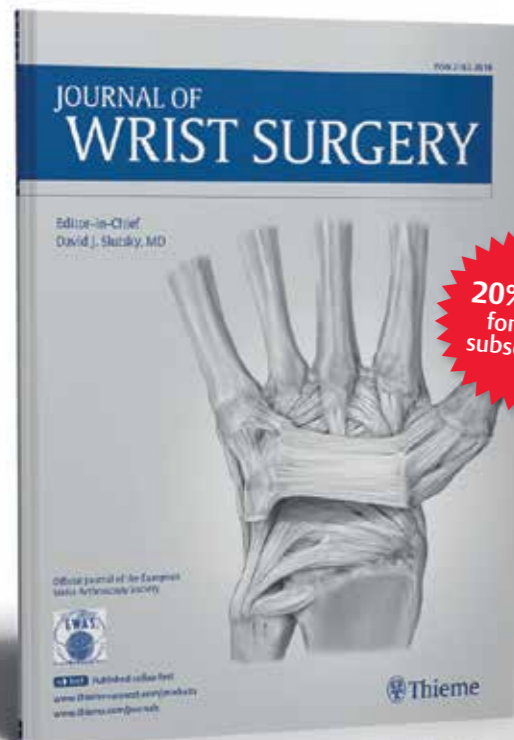


HAND THERAPY:
SCAR MANAGEMENT

IFSSH 50TH ANNIVERSARY:
BUENOS AIRES, ARGENTINA

MEMBER SOCIETY UPDATES
UPCOMING EVENTS

A quarterly peer-reviewed periodical covering all aspects of wrist surgery and small bone surgery of the hand



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IFSSH - 50th birthday celebrations

The 13th IFSSH Congress will be held in conjunction with the 10th IFSHT Congress in Buenos Aires, 24-28 October 2016. This is the first IFSSH Congress to be held in South America. May I welcome you all to Buenos Aires, the Paris of the South, with its magnificent architecture, broad boulevards, opera, museums, and the remarkable surrounding countryside of Argentina, its coast, mountains, waterfalls, vineyards and Antarctic southern regions.

The scientific programme combines the expertise of Eduardo R. Zancolli and his scientific committee with that of the Argentinian therapists led by Beatriz Inés Piso, in conjunction with the guidance of the IFSHT. The list of speakers attests to an international presence from Europe, the Americas, Asia and Oceania.

Argentina formally joined the IFSSH as an individual society in 1979, but the South American societies were represented by

the combined South American society from 1967. Eduardo A. Zancolli, the Honorary President of the Buenos Aires congress, played a major role as did the Brazilian Society, which was one of the eight founding IFSSH societies in 1966.

We will celebrate our 50th anniversary in Buenos Aires. It is fitting to remember the words of the late Miguel Vargas Busquets from Puerto Rico, who was Secretary-General from 1989 until his untimely death in 1993. He wrote that "the concept of a mother organisation that acts as a universal umbrella and the creation of new societies worldwide is spectacular".

Join us for our 50th anniversary and embrace the flamboyant and sensuous culture of Buenos Aires and Argentina.



Michael Tonkin
President :
IFSSH
Deputy Editor:
IFSSHazine

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CONNECTING OUR GLOBAL HAND SURGERY FAMILY

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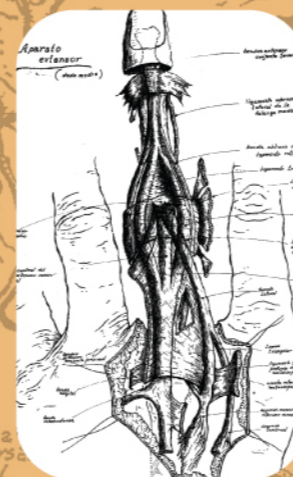
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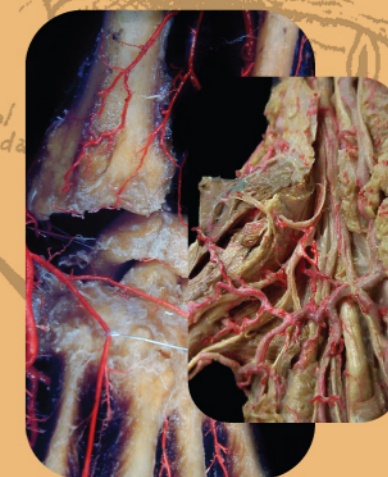
October 24-28
Buenos Aires 2016



Surgical Anatomy
Drawings by "EA Zancolli"



**Historical Hand
Anatomy
Landmarks**
in the Renaissance



**Hand Anatomy
in Argentina**
"Tribute to Elbio Cozzi"



**The Hand in
Animals**
in photographs



**The Hand in
Philately**



**The Hand in the
Evolution**



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IFSSH - SECRETARY GENERAL REPORT

Report of the on-site inspection of the congress venue undertaken by IFSSH Secretary-General, Dr. Marc Garcia-Elias, and the President of the International Federation of Societies for Hand Therapy (IFSHT), Mrs. Sarah Ewald, on December 4th, 2015

Dear friends:

I started working on this report in the darkness of a bumpy aircraft, night-crossing the Atlantic, on my way back home. In the previous 48 hours, we had inspected the facilities of the convention center that will hold our next congress in Argentina, we had discussed different aspects of the scientific program (plenary lectures, debates, hands-on sessions, combined activities with the hand therapists, invited lectures, free paper presentations), and we had visited the sites of the social events being planned for that occasion. I was tired, of course, but also very pleased with all I had seen.

As you know, the IFSSH bylaws state that one year before the Federation's triennial congress, a representation of the Executive Committee must visit the site of the meeting. The goal: to ensure that the venue is adequate, that

the accommodation is comfortable and that all the preparations (importantly, the scientific and social programs) are properly under way. Mrs. Sarah Ewald, the President of the International Federation of Societies for Hand Therapy (IFSHT), also attended the inspection as this 2016 congress

“Nothing can stop this from becoming a successful meeting, thanks to the generosity of the members of the Argentinean Association of Hand Surgery

is a joint meeting of the IFSSH and IFSHT. The date of the onsite inspection, 4th of December, could have not been more appropriate: it coincided with the celebration of the annual meeting of the Argentine Association of Orthopedic Surgeons, one of the largest meetings of that country. This allowed us to see how efficient our future venue can be in the presence of more than 3000 delegates. We are grateful to the Orthopaedic Association and venue staff for allowing us to join all the session rooms and their backstage areas (kitchen, laundry, etc): impressive facilities, indeed! What we saw was very convincing: choosing the Hilton convention center had been an excellent idea. It is a modern, carefully maintained convention venue with session rooms of varying sizes, all well equipped with state-of-the-art audiovisual technology. The industry/trade groups will enjoy roomy spaces for their commercial exhibits. The accompanying persons will benefit from an enormous lobby with plenty of little spaces to plan their next tourist adventures or just to relax while appreciating a great variety of tea blends.

And all of this is just right in the center of Puerto Madero, one of the trendiest boroughs in Buenos Aires and one of the most successful recent waterfront renewal projects in the world. Since the 90's, all warehouses on the west side of this old harbour were recycled into elegant offices, lofts, luxurious hotels and restaurants. On the east side, a new district of cinemas, theatres, cultural centers, and corporate buildings has emerged. This will be the backdrop of our meeting. I am sure that you, the delegates, will enjoy the place, as much as I did. But if you are still not convinced, maybe you should watch "Nine queens", a great thriller by Fabián Bielinsky. Most of this movie was filmed in the Hilton Hotel, the venue of our meeting, and its surroundings. It's worth watching, particularly the last 50 seconds! (<https://www.youtube.com/watch?v=IN3LIzcLGJY>) You'll fall in love with that place.

During our visit to Buenos Aires, we were hosted by the President of the 2016 IFSSH/IFSHT Congress, Dr Eduardo Zancolli and his colleagues. One of his first remarks, on our way to the congress venue, was: "For the last two years we have had weekly meetings to ensure that everything, scientific program included, was ready for this inspection". They had made it - the site was not only ready for inspection, the meeting was almost ready to go. All important decisions have been made, all facilities reserved, and the process of collecting abstracts

is under way. Nothing can stop this from becoming a successful meeting, thanks to the generosity of the members of the Argentinean Association of Hand Surgery. Their determination in hosting this event is unparalleled. I am sure that nobody will leave Buenos Aires unchanged. Thank you, Eduardo, for so expertly leading this team!

There is another reason for this upcoming meeting to be very special. It will be held 50 years after the 1966 founding meeting of the IFSSH in Chicago. Initially formed by only eight hand societies (Italy, Japan, USA, UK, Sweden, Germany, Brazil and France), the IFSSH has grown enormously since. We are now 56 societies from all over the globe, and the prospects for the future are excellent. Let's take this opportunity to have a much deserved celebration.

On a related topic, in early 2016 we will send a call to the delegate of each IFSSH society for nominations of Pioneers in Hand Surgery. Remember that the nomination must come from the IFSSH member society, not an individual, and should be reserved for those with outstanding achievements. Details of the criteria and nomination process are available on the IFSSH website: <http://ifssh.info/pioneers.html>. The deadline for submitting nominations for the Buenos Aires congress is April 24th, 2016.

During the Buenos Aires Congress,

the IFSSH Delegates' Council will also be assessing applications to host the 2022 Triennial Congress. The guidelines for these submissions are also on the website: <http://ifssh.info/guidelines.html>

In short, our Argentinean colleagues are ready. It is time to go and join them. The 2016 IFSSH/IFSHT congress will be one of the best, if not the very best!

XIIIth IFSSH – Xth IFSHT Congress
October 24-28, 2016 - Buenos Aires, Argentina

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



LOOKING BACK the last 25 years - the lessons learnt

Dr. S Raja Sabapathy, MS, M.Ch, DNB, FRCS(Ed), MAMS

I came back to Coimbatore, a tier 2 city in South India in 1991, after training in Stoke Mandeville and Canniesburn in the UK for 2 years and Louisville, USA for a year. My brother, an orthopaedic surgeon, who spent 3 years in the UK returned at the same time and together we set up a specialty centre for trauma in a 35 bed hospital which our parents had started earlier. I have had my basic hand and plastic surgical training with Prof. Ramaswami Venkataswami, the doyen of Indian Hand surgery. Before our arrival, Ganga Hospital was a polyclinic, catering for all specialties. Our main thrust was to create a centre which would cater for major trauma and introduce microsurgical reconstruction. At Coimbatore till that time, no one had specifically projected himself as a hand surgeon. Our senior nurse everyday kept telling me that my name tag evoked surprise among

people and she had a tough time explaining to people the term 'Hand Surgeon'. One day she suggested that I take off the tag 'Hand Surgeon' because again, one patient had just confronted her stating: 'What is special about this? I thought everyone operates with their hands'. He could not even think that someone can specialise in hand disorders.

Picture of my brother Dr. Rajasekaran and myself



But we held on. In the time between 1991 and 2014, lots of things have changed. We have become one of the busiest hand trauma reconstructive surgery units with 9500 surgeries every year, and attracting about 100 surgeons from all over the world to visit us. It is nice to go down memory lane and think of the factors which made this possible. When we started, many with good intentions advised us that we should do sessions in major hospitals, because major injuries will come to major institutions and not to a start-up unit. But we were very keen to develop the institution which our parents had nurtured with so much difficulty.

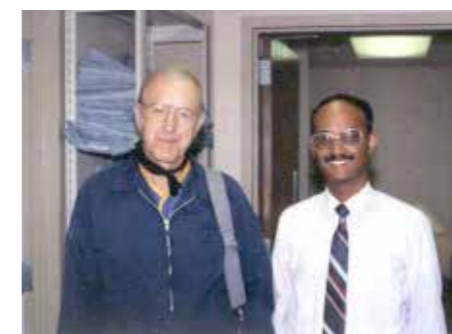
Before coming back, I spent the last few months of my fellowship at Louisville with Dr Harold Kleinert. A genial man, who could sometimes utter some words which would have a great impact on one.

When I used to discuss the starting of a Hand Surgery Centre with emphasis on hand trauma in India he infused the 'can do it' feeling. The basic tenet against its success was that the injured people were poor and that they cannot afford treatment in a private set up. At the time of our coming back the insurance penetration in India was just 2 %. To that Kleinert used to say:

“As long as you love doing hand surgery, and keep doing good hand surgery without worrying about money, everything else will take care of itself

That was comforting to hold on in the beginning.

Myself with Harold Kleinert during the Louisville Fellowship.



The other advice he gave was the need to have the three 'A's to start a hand injury service: "Availability, Affability and Ability" in that order. This again was making us persist to stay in one place. Things do not work out immediately and it is one's good fortune if some encouraging signposts become available. In the beginning, since I had little work to do and a lot of time at hand, I used to attend all medical meetings in the city using it as an opportunity to meet people and talk about microsurgery. Microsurgery was new to the region. The guiding light came in the form of a lecture by Mr Thulasiraj, executive director of the Aravind Hospital in Madurai. Aravind Hospital is a marvellous model of eye care. Its founder Dr Venkataswami started it after his retirement from Government service at the age of 58. In a span of 15 years Aravind had become the foremost eye care provider of the world. They had a purpose of 'preventing needless blindness'. In the lecture, Thulasiraj explained the need to have a good purpose and that the power of good purpose

is unlimited. One just needs to relentlessly chase that purpose. Aravind presently does more than 250,000 surgeries a year, treats more than 60% of them totally free, still makes a profit, is debt free and has become a Harvard business school study model for healthcare delivery. He went on to say that only 8% of patients with blindness due to cataracts in India were getting operated when they began and that all the doctors were fighting within that small market share. Aravind just concentrated on the underserved 92% of the population and grew. Three factors were identified for people not being in the service net. Some were ignorant that treatment was possible, some knew, but did not know where to go, and the rest knew where to go but could not afford the treatment. Aravind's answer to the problem was to educate the masses, project the place and subsidise or offer free treatment. It worked.

At the end of the lecture, I walked up to the speaker and told him of our goal of starting a hand injury service and wondered if the same principles would apply. He gave an emphatic 'yes' and wished us all the best. The idea was clear – we need to have a good purpose and relentlessly chase it whatever it takes. We articulated our purpose of "Preventing needless morbidity due to hand injuries". The idea was to prevent hand injuries, but we should be treating all the hand

injuries that occur in the region. So we printed some brochures – one on the need for safety in the workplace, one on first aid for hand injuries and one on microsurgery for hand injuries. It had a remarkable effect. Many industrialists said that the number of injuries definitely reduced after they put up the posters and they sent us all the patients when injuries did occur.

Once the patient flow started, the problem of affordability came in. We were very keen to do replants. We were struck by the stark reality that no one got injured with money in the pocket. If they needed replants we just had to do it. So we kept doing and every time we succeeded, it brought in a lot of good will. Some did not pay, many paid much less, but overall because of volume we did fine. If the replant failed it was possible to charge the patient only for the closure of the amputation stump. That kept us really on the fence to perform at our best all the time. If I lost a replant, all of us lost - myself as surgeon, anaesthesiologist and the hospital. I should pay a great tribute to our anaesthesiologist Dr Bhat, whom we unfortunately lost a few years ago, (read: 'Game changer in trauma care' at www.gangahospital.com) and to our parents who allowed us to pursue our dreams without worrying about the financial part of the equation. It is said that 'in the decision making process, if you leave out money, you make the right choice, and the right choice leads to money'.

right choice leads to money'. It did for us. We expanded from 35 beds in 1991 to 135 beds in 1997 and to 420 beds in 2007 and presently we have 480 beds catering just for the two specialties of Plastic and Reconstructive Surgery and Orthopaedics.

“
In the decision making process, if you leave out money, you make the right choice, and the right choice leads to money’

The system was established that no one paid on arrival. We would explain the cost involved, and in an emergency what needs to be done will be done irrespective of the patient's ability to pay. That decision helped us to build the brand Ganga. People felt that 'if you get hit, if you go there they will take care'. In healthcare so much depends upon trust. The trust grew every time we saved a life or a limb. The close collaboration of

the Plastic and Orthopaedic teams supported by an incredibly efficient anaesthesiology team made it possible.

The model I think is replicable, but it needs a total conviction in the purpose. It has to be matched with good skill, and incredible hard work. The conviction of the purpose helps you to put in the work and makes the effort enjoyable. It can also draw in people who share the same vision. At present when medicine is at the crossroads with so many young people seeking direction, I am convinced of what Harold Kleinert said that day holds true, 'As long as you love doing hand surgery, and keep doing good hand surgery without worrying about money everything else will take care of itself'. The only things required are the love for doing it and development of skill.

The high volume – high quality – affordable cost model cannot be achieved without a great team. We are fortunate to have gathered a group of people, who have sacrificed their smaller goals for a shared big one. It demands hard work from everybody. For the first two decades I have not heard the words, 'Work – Life balance'. I think the way to achieve it is a very personal thing. All great things can be achieved only with the support of the family. Achievements have no meaning if the family does not rejoice the accomplishment. The



Ganga Hospital in 1991

key is to get the family involved in what we do and they take pleasure and pride in our professional success.

'Work – life balance' has two words. One is work and the other is life. First of all we need to think what gives us this life. It is our work that gives us this life and hence we can't complain about it. It is my feeling that people talk about work--life balance when they do not achieve their goal or are not clear as to what they want in life. I am convinced that it is not the amount of time you spend with your children or family but how you spend the amount of time that you have. Just as in healthcare, here also it revolves around trust. Once I had a young girl from a poor family just out of school ready to join college. She had gone to do a part time job in a textile company to get some extra money to buy books. Unfortunately she sustained a dorsal composite loss of the hand. She needed a flap cover and it took us about 4 weeks to get her wounds healed. Throughout the stay, an old lady stayed with her and I never saw her parents after



Ganga Hospital at 1997 (the first block in the background)

they admitted her. When they came on the day of discharge, I just started asking them how they could be so heartless not to come even for a day when their daughter had such a severe injury and as to what her daughter would think of them. I felt humbled when her father answered, 'Doctor, please don't get angry. We love her a lot. Throughout this period both my wife and I worked extra hours so that the life here will go on. We wanted our daughter to get the best care possible'. I am sure the absence of her parents at the time of need would not have mattered to the daughter because she knew that they are doing it for her. In life it is important to build that trust. It is built by frequent communication and sharing of the vision. In the answer of the parents there are the two words – work and life and there was a successful balance.

Early in my career, an incident left a lasting impression. I shared the dais at the annual day of a Physiotherapy College with Mr Ali Irani, the chief physiotherapist of the Indian cricket team. A person



Ganga Hospital in new premises in 2007

introduced me as a 'doctor with terrific stamina, since he operates daily for 10 to 15 hours'. I tried to downplay that, stating that Mr Irani deals with our national cricket team players who have greater stamina. To this Mr Irani replied, 'Stamina is purely a mental attitude, not a physical attribute'. He said that if you can perform or do a thing which needs to be done, when you are physically tired or you don't like to do it, then you have stamina'. He went on to say: 'Operating for 15 hours does not mean that the surgeon has good stamina, but when he goes home, and if his daughter asks, "Dad, shall we go for an ice cream", and if the surgeon then could say: "Well that is a good idea, let us go" then he has stamina'. That conversation helped me to put our professional work in a right perspective so often.

After the unit became busy, two things became obvious. With time, you only work harder and longer. This was in spite of the team becoming bigger. Then I understood the words of Harry Buncke: 'I always thought it is

going to get easier, but it never does'. How to keep going? I think one needs to see the larger picture of one's work. If in the middle of the night we see a child who needs a radical debridement, humerus fixation, repair of the brachial artery and then cover the wound by a pedicled latissimus dorsi flap which will serve both as cover and elbow flexor, then one need to be at his best till the end of the procedure. The individual technical steps look daunting, particularly at night. But if we consider that our efforts that night will give the right arm back to the 10 year old child, that she will be able to play with her friends as before, will pursue her dreams at college, get married and raise a family, then we get the extra push to continue on with attention to detail. It is the ability to see the larger picture of our efforts that can keep the leader of the team to keep on going. Timing of team building and choosing of the team members is very important. Once again to quote Harold Kleinert: 'I don't mind selecting a monkey when I choose a fellow. All I want is an interested monkey. Interest in hand surgery is important. But

when you want to choose a partner, don't just rely on skill levels. He or she must be acceptable to the people in the unit, to the staff, to the therapists, to the secretaries and so on'. It was a great education to me whenever I had to make a decision in expanding our unit, then I think back on this advice.

The hard work and the team effort got the unit to the leadership position in the region. I very soon realised that leadership is not a permanent entitlement. This is not a challenge exclusively for the medical profession. Even Bill Gates has said: 'History has shown that the leader of a field in one generation is not the leader in that field in the next generation. I am afraid of history and I want to beat history'. The periods of leadership is getting shorter and shorter. In some professions, like sports and cinema it may even be only a few months.

Bob Acland visited our unit in 2006, and he wrote the following words in our visitor's book. 'I am happy that I am in the United Nations of microsurgical progress and education. This feels the same in

terms of energy and excitement as Louisville in the seventies and Ljubjana in the eighties. My best wishes for your continued success'. Though it made us jubilant that he compared us to renowned units, it also made me feel that he has given a decade for each unit. Later that night I talked to him about it and our discussion went on to the rise and fall of institutions. Bob Acland said that he found 3 common threads in the fall of all great institutions. First was 'Celebrating success'. He said that once a unit succeeds, a sense of invincibility creeps in and the founders keep on explaining how they succeeded, not giving their unit the vital push all the time. The second was: 'You will train the world, but may not take care to train the people who will be working with you. The skills of the next generation must be honed up'. And the third and the most important: 'Over a period of time, forgetting the core values which brought you up to this level in the first place'. The points were delivered like someone hitting the head with a brick. They all appeared so true when looking at some units in hindsight, and I constantly try to keep them in the

back of my mind to prevent us from wavering from the course we have set for ourselves.

The last 25 years has also taught me that it is impossible to have any direct effort – reward relationship. One has to just follow the heart and do what one likes, to do what is right without thinking of the effects. Time and again instances have proved this right and I will just quote two incidences. India, although it joined the IFSSH, never paid its dues to the Federation from the beginning. Dr Amit Gupta my good friend, wished that we host the meeting in India and after the Finland meeting told me that India is not a member of good standing since we have not paid the dues and in that case we can't bid for the meeting. During the next meeting in Vancouver, in the corridor both of us were talking and I told Amit Gupta: 'Amit you give me US \$ 500 and I will take it as the subscription and will attend the council meeting.' It was, but an impulsive decision just to erase the label, 'not a member of good standing', from our country's name. Dr Guy Foucher was the President of IFSSH and he was very welcoming and Dr Lam Chaun Teoh helped to keep the butterflies off my stomach when I went in to attend the council meeting. Thereafter we regularly paid the subscription by personal contributions. To our own surprise we won the bid to host the IFSSH meeting just 3 congresses later at Sydney. At the time when we joined

the council meeting in Vancouver little did we realise that we will host the IFSSH 2013 Congress.

Similarly, when I came back from Louisville, I had a great desire to set up a micro lab like the one founded by Acland at Louisville. I came back with the tapes, but it took 10 years to manage the funds to get the microscopes for the lab. In the beginning it was a great loss making venture, but now it has become one of the busiest micro labs in the world with about 75 surgeons taking the course every year. It has helped surgeons from 50 countries to visit us and so far around 720 surgeons have taken the course. When we started the lab we never thought that it will bring in international trainees. Now I feel that our lab contributed to showcase our work to the world. I am very convinced that in major decisions one has to just follow the heart and be passionate to the cause and things will work in a bigger way than we even could imagine.

That is exactly what the great Indian philosopher Swami Vivekananda said: '**Take up one idea. Make that one idea your life; dream of it; think of it; live on that idea. Let the brain, the body, muscles, nerves, every part of your body be full of that idea, and just leave every other idea alone. This is the way to success.**'

Dr. S Raja Sabapathy, MS, M.Ch, DNB, FRCS(Ed), MAMS

Chairman, Division of Plastic Surgery, Hand Surgery, Reconstructive Microsurgery and Burns

Secretary General, Asian Pacific Federation of Societies for Surgery of the Hand

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Indian Society for Surgery of the Hand
Indian Society for Reconstructive Microsurgery
International Trauma Care (Indian Chapter)
Brachial Plexus Surgery Group of India – 2011 – 13

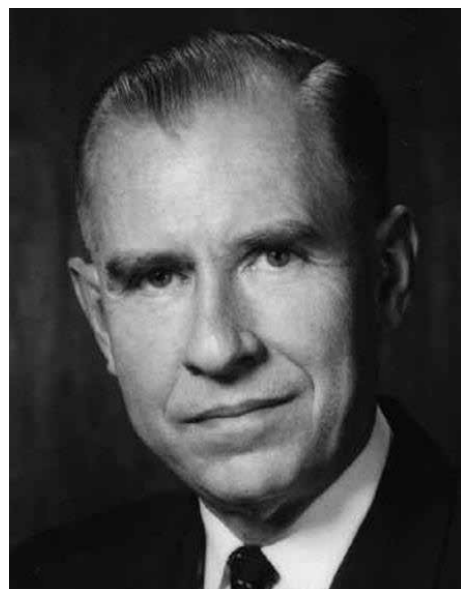
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Based on the A C Boonzaier Eponymous Lecture, South African Society for Surgery of the Hand Congress, 2014, Cape Town



Tier 2 City of Coimbatore with heavy traffic and many pumps and textile manufacturing companies

GEORGE S PHALEN, MD



Dr. Phalen was born in Peoria, Illinois. He completed his premedical studies at Bradley University where he received the Scheele Medal in Chemistry (1932) and later the Distinguished Alumnus Award (1970). He earned a Master's Degree in Anatomy, and a Doctor of Medicine Degree from Northwestern University Medical School, Chicago in 1937 and was also a member of the Alpha Omega Alpha (1936) and Sigma Xi (1937) Societies. After completing a three year residency in orthopaedic surgery at the Mayo Clinic, he entered the United States Army during World War II in 1942. He served for four years as Chief of the Orthopaedic Section at O'Reilly General Hospital, Springfield, Missouri. This hospital was one of seven Army hospitals in the United States chosen by Dr. Sterling Bunnell as an Army Hand Center. He was then Chief of the Hand Service at William Beaumont General Hospital, El Paso, Texas for six months.

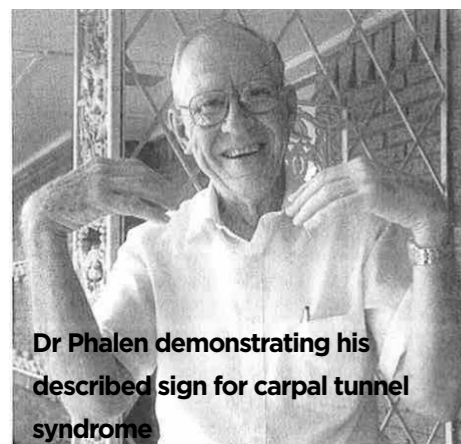
Upon discharge from the Army, Dr. Phalen established his practice of orthopaedic and hand surgery at the Cleveland Clinic in Cleveland, Ohio where he was also Associate Professor of Orthopaedic Surgery (1946-70). He then practiced at the Dallas Medical and Surgical Clinic until his retirement in 1980.

In 1948, Dr. Phalen brought the diagnosis of Carpal Tunnel Syndrome to the attention of doctors in the world when he presented his paper at the annual meeting of the American Society for Surgery of the Hand. A diagnostic sign of the Carpal Tunnel Syndrome bears his name.

Dr. Phalen is a Founding Member of the American Society for Surgery of the Hand and helped organize the first meeting at the Palmer House in Chicago in 1946. He was Secretary-Treasurer (1954-57) and President of the Society (1961). He was also Vice-President (1963-64) and President (1965) of the Association of Bone and Joint Surgeons. He was on the Board of the Orthopaedic Section of the American Medical Association for ten years and served as Chairman in 1969. Dr. Phalen

was a member of the Examining Board of the American Board of Orthopaedic Surgery from 1965 to 1969. He served the American Academy of Orthopaedic Surgeons on the Regional Membership, Instructional Course, Development of Orthopaedic Research and Resolutions Committees. Dr. Phalen is also a member of the American Orthopaedic Association, the Clinical Orthopaedic Society, the American College of Surgeons, SICOT and a number of other professional organizations.

At the Sixth International Congress of the IFSSH, held in Helsinki, Finland, on the 3rd of July 1995, George S Phalen was honoured as "Pioneer of Hand Surgery"



Dr Phalen demonstrating his described sign for carpal tunnel syndrome

ALFRED B. SWANSON, MD, FACS



Dr. Swanson received his undergraduate and medical education at the University of Illinois and his training in orthopaedic surgery at the Universities of Illinois, North-western and Indiana. During the Korean war, he served in the U.S. Army as an orthopaedic surgeon before establishing his practice in Grand Rapids, Michigan. He has been particularly concerned with the care of crippled children, congenital malformations, impairment evaluation, surgical treatment for arthritis, training of physicians, international medicine and the environment.

Dr. Swanson is Director of the Grand Rapids Orthopaedic Surgery Residency Training Program, and Director of Orthopaedic Research and Hand Surgery Fellowship at Blodgett Medical Centre. He is Professor of Surgery at Michigan State University. He has trained more 110 orthopaedic residents and 100 hand fellows from over 35 countries. Actively involved in medicine nationally and internationally, he is a member of numerous boards and societies. He has participated in 650 congresses in 56 countries, and has published upwards of 250 scientific papers and 50 book chapters, as well as a book.

He is Past-President of the ASSH (1979). He was Secretary General (1976-1983), President (1983-1989) and Historian of the IFSSH. He received the Kappa Delta Award for research from the American Academy of Orthopaedic Surgery in 1982 and the Distinguished Alumnus of the Year Award of the University of Illinois in 1985.

Dr. Swanson has revolutionized the surgical treatment of the arthritic hand, upper extremity and forefoot since 1962 through his research and development of metal, silicone and other implants for joint reconstruction. He has pioneered the use of closed-circuit television for live surgical demonstrations. The Grand Rapids International Symposium on Implant Arthroplasty was established by him in 1973, and has been attended by thousands of physicians from more than 40 countries. Feeling that medicine has an important role in world peace and diplomacy, Dr. Swanson, in cooperation with Care-Medico and the American Society for Surgery of the Hand, organized a medical aid program for South Vietnam staffed by international volunteer surgeons from 1962 to 1975. He received the Medal of Honour from the South Vietnamese government for his care of the wounded and for organizing a polio immunization program. He organized a similar volunteer program for Peru. Realizing that future world problems are related to the environment, he is Founding Chairman of the Alternative Methods for International Stability (AMIS) and of the International Trees Corps.

Dr. Swanson is very proud of his family and his children Eric, Miles and Karin and their families, and especially of his wife Dr. Geneviève de Groot Swanson, who has been so important in his life and work.

For the enormous contribution to Hand Surgery nationally and internationally, Alfred B Swanson was awarded the "Pioneer of Hand Surgery" honour on 3 July 1995 at the Sixth International Congress of the IFSSH in Helsinki, Finland. Further recognition was given by the IFSSH in naming the keynote lecture at its triennial congresses the "Swanson Lecture"



IFSSH Scientific Committee on **Arthritis** (Rheumatoid and other inflammatory conditions)

Chair: Daniel Herren (Switzerland), Kevin Chung (USA)

COMMITTEE: YOSHITAKA MINAMIKAWA (JAPAN), ALFREDO OLAZABAL (ARGENTINA)

REPORT SUBMITTED SEPTEMBER 2015

What surgeons need to know about rheumatoid arthritis and its current medical treatment

Nothing has changed the face of rheumatoid arthritis (RA) as much as the medications that help to control the inflammatory aspects of the disease and reduce joint and soft tissue destruction in most patients. Because biologics not only act locally but also have a significant impact on the patient's immune system, they affect both the surgical treatment itself and patient management before, during, and after surgery.

RA is best characterized as an immune-mediated inflammatory disease. It is the most common inflammatory arthritis and affects about one percent of the population. The disease seems to be initiated by a complex combination of genetic predisposition and unknown extrinsic factors. The main tissue involved in RA is the synovial membrane in joints and around tendons. In RA, the synovial

membrane is hypertrophied in all its layers, is heavily infiltrated by inflammatory cells and shows angiogenesis. The hypertrophied synovium, also called pannus, erodes cartilage and bone to leave significant defects. The driving cytokines in this process are interleukin-1 (IL-1) and tumor necrosis factor alpha (TNF α). Bone destruction is mainly driven by macrophage-induced osteoclast activation. A major development in the identification and prognostic factors of RA was the detection of antibodies to cyclic citrullinated peptides (anti-CCP), which are part of the autoimmune reaction. The presence of anti-CCP is more than 98% specific for the diagnosis of RA and generally represents a more aggressive phenotype of the disease. Rheumatoid factors are less specific for RA and are also found in other chronic inflammatory diseases, such as hepatitis C and tuberculosis.

There are many different pathways leading to this disease and no single disease agent that explains the

pathogenesis. Interleukins, T and B cells, and macrophages interact in a complex manner to initiate and sustain the inflammatory process. This probably explains the different success rates of the various pharmaceutical agents.

The goal in treating RA is to gain control over the inflammatory processes in the synovial membrane and prevent joint destruction. The common principles that guide management strategies and the choice of medication were derived from an increased understanding of the disease and from evidence provided by clinical trials and other studies. The anti-inflammatory potency of the different drugs can be defined in a therapeutic pyramid. The first stage of pharmacotherapy includes non-steroidal anti-inflammatory drugs (NSAIDs), which mainly act as prostaglandin synthesis blockers. The next level consists of glucocorticosteroids, and then come the disease-modifying anti-rheumatic drugs (DMARDs). Methotrexate (MTX)

is the best-known and most popular DMARD. It acts as an antimetabolite in the form of a folic acid analogue. Its main effect in RA depends on the inhibition of T cells.

Biologics, at the next level in the RA medication pyramid, were developed in the late 1990s. Their name was given according to the way in which they are synthesized, as genetically engineered proteins derived from human genes. Among the biologics, TNF α inhibitors are the first-line treatment after DMARD failure. All the other biologics are not usually considered unless the therapeutic effects of anti-TNF α are not sufficient. Several targets besides TNF α are used to combat the complex inflammatory process in RA. Medication includes IL-6 blocking agents. They are often combined with MTX but can also be used as mono-therapy in cases of intolerance or contraindications to MTX. The newest developments are the bio-similars. These drugs are based on the different action modes of existing biologics. Because the older generation of these drugs no longer provide protection, the bio-similars are copying the mode of action but the bio-genetical engineering is different and cheaper. The average cost of biologics is up to USD 2000 per month, compared with about USD 70 per month for MTX alone. In order to justify the high costs, prediction of the individual response to treatment has become a major clinical challenge in RA.

Ideally, the goal of all of these drugs

is remission of the disease, which is defined as the absence of disease activity but with the possibility of return. The remission rate of all these biological substances is around 50%, compared with a remission rate of around 30% for MTX alone.

“Owing to modern treatment regimens, the number of surgical procedures has declined in most countries

The adverse effects observed in RA patients treated with biologics are another concern. Besides the general adverse reactions, surgeons are especially interested in the discussion about possible increases in surgical site infections when immunosuppressants are administered in RA. Classic adverse reactions to MTX and even more to biologics include infections with opportunistic pathogens such as atypical fungi and mycobacteria. An increased risk of malignancies

including melanoma is also suspected. Because the incidence of these adverse reactions is still low, most studies lack sufficient statistical power to provide evidence of a strong correlation.

Although several studies and long-standing personal experience show that MTX, even in combination with corticosteroids, does not increase the risk of surgical site infections, there are major concerns about the use of biologics in a perioperative setting. Based on several studies and personal experience, there is an informal expert consensus that interruption of the biological therapy is advisable for major surgical interventions such as joint replacement surgery, especially of larger joints. There is some debate as to whether corticosteroids and/or MTX should be given in the perioperative phase in order to reduce the chances of disease flare-up.

Interruption of biologics prior to surgery should be managed according to the administration time of the medication. Usually one cycle is omitted prior to surgery. The medication is restarted after the delay of another cycle or once wound healing is assured. However there are no precise data on this management.

Clinical observations indicate that the course of disease in patients with RA has become milder during the past decade. Less severe symptoms, as well as the diminishing need for orthopedic interventions, are most likely the result of the more potent

drugs described previously in this chapter. There is an ongoing debate whether the type and frequency of surgical intervention have changed significantly in RA patients in recent years. Because the hand is still the main treatment target in these patients, as the hand is affected in almost 90% of patients ten years after the onset of disease, it can be used as an index intervention. Several studies have indicated a decline in the number of orthopedic interventions in RA patients over the last two decades, especially the numbers of hand and foot interventions have declined in the western world. However, there are reports of possible changes in that trend, particularly in Japan. There are various possible explanations for this phenomenon. One possible explanation is that the new medications improve the patients' quality of life, which in turn increases their level of participation in social activities and work. These highly motivated patients place greater demands on both the functionality and the appearance of their hands and feet, so tend to seek surgical assistance more often. The appearance of the hands, as well as the feet, has a high value in societies like the Japanese, and deformities can lead to social isolation. The aesthetic aspects of these interventions should therefore not be underestimated.

Not only the number of surgical interventions has changed since the introduction of the new medications, but also the type of

procedure. Previously common procedures such as wrist fusion and metacarpophalangeal arthroplasties have become rare nowadays, whereas other surgical interventions, including wrist arthroplasties and PIP replacements, are now seen more often in RA patients. There are reports about differences in the clinical and radiographic appearance of patients treated successfully with biologics. The radiographs started to look more like those of people with osteoarthritis than those of patients with chronic inflammatory disease. On the one hand, this has changed the indications for certain interventions because good medication has the potential to improve surgical results in the long-term.

Summary:

- Owing to modern treatment regimens, the number of surgical procedures has declined in most countries; however, there is a trend towards recurrence of the disease after 4-5 years of anti-TNF α treatment, possibly because of antibody formation to the medications.
- The pattern of RA patients being treated surgically has changed: these patients now either have isolated residual synovial inflammatory processes or are non-responders with a more severe pattern of disease showing gross destruction.
- Methotrexate and corticosteroid medication can or even should be continued during surgical

procedures.

- Whether anti-TNF α medication should be discontinued during surgical intervention is still open to debate, as no clear evidence of a higher risk of infection can be found in the literature. If infection should occur, however, its course might be more severe.
- If anti-TNF α medication is discontinued, the administration interval of the particular biologic must be taken into consideration, as there are substantial differences between products.
- There is a subset of patients with a disease pattern resembling degenerative arthritis with a mild inflammatory reaction; these patients can be treated according to the surgical principles for degenerative arthritis.

Optimal scar management techniques for optimal hand function and aesthetics

“Hand therapists are, in truth, scar therapists”- Fess, 1998



Meghann Berchtold



Vera Beckmann-Fries



Christine Meier Zürcher

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Every injury to the skin starts as a wound; every wound ends with a scar (Figure 1). As hand therapists we have all seen the impact that scarring can have on patients emotional and functional outcomes. Correct assessment and optimal management of scars is an integral part of the rehabilitation process, it assists in reducing pain and impairment to allow for optimal strength, range of motion and patient satisfaction. In the hand therapy department at University Hospital Zürich we practice a range of methods to ensure the best possible healing and function of scar tissue through:

- Scar massage
- Passive and active mobilisation
- Use of silicon
- Taping
- Thermal Modalities
- Compression
- Iontophoresis
- Patient education

Figure 1: Developed scar tissue



Scar Massage

Scar massage helps to soften the scar tissue resulting in increased flexibility and releasing adhesions by shifting the tissue layers against one another. Following the removal of stitches and complete healing of the wound, light massage can begin. A young scar cannot tolerate direct tensile force. Following 3 weeks from the initial injury the newly formed scar regains 15% of its strength. Although this seems relatively weak, it allows for controlled movements and pressure. Pressure to the tissue leads to improvements in tensile strength (Hardy, 1989). The scar tissue regains 50% of the expected strength after 6 weeks (Walder-Nielsson, 2009).

Massage can be performed with or without the use of aids and creams. Creams and oils are used to soften the scar tissue, however, in order to mobilise scar tissue, creams and oils are not recommended. Equipment such as specifically designed tools, vacuum pumps and 'non-slip' plastic can be utilised to mobilise scar tissue, depending on the goal of treatment.

The use of 'non slip' plastic (Figure 2) allows for controlled grip of superficial layers of skin, making it easier to shift these layers against the deeper tissue. 'Non slip' plastic can also be used to provide resistance to the superficial layers of soft tissue while actively mobilising deeper layers against this resistance and thereby separating adhesions.

Figure 2: Scar massage with use of 'non slip' plastic



Vacuum pumps (Figure 3) assist in separating the deep tissue layers. Application of the vacuum pumps should be carefully administered to ensure that no further micro trauma is inflicted on the area which can cause further scarring and prolonged healing. Specifically designed wooden tools

Figure 3: Scar massage with use of Vacuum pumps



(following the Hentschel method) allow the therapist to apply the massage to precise structures through their uniquely formed wooden design (Figure 4) (Hentschel et al., 2006). An important yet often forgotten advantage of such tools is the protection they provide to the joints of the treating therapist.

Figure 4 : The Hentschel method



Mobilisation

Mobilisation is conducted to elongate the scar and shortened tissues to achieve the best possible elasticity of the soft tissue as well as range of motion in the corresponding joints. Scar tissue can achieve a maximum of 70-80% of the skin's original elasticity and tensile strength (Waldner-Nielsson, 2009). During the remodelling phase of scar formation, aligned collagen

is formed in both linear and lateral orientations. Forces influence the realignment and orientation of these collagen fibres. Two theories are given to describe these forces (Hardy, 1989): The induction theory: scar tissue will form the same characteristics as the tissue it is healing. Dense tissue will produce a dense scar through increased cross links while supple tissue will produce a looser, pliable scar with fewer cross links.

The tension theory: controlled tensile force during the remodelling phase of wound healing influences the remodelling of collagen. Hand therapists typically practice the tension theory through splinting and patient tailored exercise programs. Splints that provide a low-load force to the tissue help in remodelling collagen without causing further injury to the area (Fess & McCollum, 1998).

The most common splinting methods are:

- Dynamic Splints provide tensile force to the involved joint and tissue through the use of a rubber bands, elastic, springs or soft splints made from neoprene (Figure 5,6)
- Static progressive splinting allows the tissue to adapt to a fixed position, requiring ongoing modifications from the therapist to adapt the position
- Serial casting allows the tissue to adapt to a fixed position using a series of closed casts designed to provide stretch to the affected joints and tissue. These casts should be periodically reviewed and changed as needed.

Active range of motion

Early controlled active range of motion, tailored to the patient and injury, helps to prevent scar adhesions and contractions and thereby increases range of motion and decreases pain. This theory is supported through the study of post-operative treatment of patients following flexor tendon repair. Early mobilisation resulted in optimal tendon gliding and reduced scar adhesions (Jones, 2005).

Figure 5: Finger splint made from Neoprene



Figure 6: Use of dynamic splinting to mobilise scar tissue



Silicon

The use of silicon assists in flattening scar tissue and reducing redness. There are many available forms of silicon which can be used in the management of scars. These include self-adhesive sheets such as Cica-Care® and Mepiform®. Silicon is occlusive, it has a water evaporation rate which is lower than our skin (Evans & McAuliffe 2002) and is therefore helpful in preventing loss of moisture. Although Silicon has no direct influence on the progression of the scar tissue, through its occlusive seal, it supports the ongoing management through the effect of increased hydration (Chang et al., 1995). Silicon use during sleep or during a period of immobilisation ensures that the scar is being treated when other therapy options are limited. Patients should be advised to wear the silicon for as long as possible, at least 12 hours per day (Waldner-Nilsson, 2009).

Taping

Both elastic tapes and non elastic tapes are a useful, effective measure in scar management. Once appropriately applied, they can positively influence the development of scarring without any further effort, making them appropriate for patients who find it difficult to manage other forms of scar management techniques. Depending on their placement, elastic therapeutic tapes such as Kinesio-Tape® or Easy tape® can provide a cross fibre friction massage or a passive stretch to the scar tissue (Figure 7). Patients have also reported that tapes provide an easier grip when conducting their own 'one handed' scar massage.

Non elastic tapes such as Micropore™ or Steristrips™ are useful in reducing stress to the area, for example, using a cross formation with Steristrips™ over a scar on the dorsal aspect of the hand. Both Elastic and non elastic tapes provide the added benefit of compression of the tissue.

Figure 7 -Taping can provide a cross fibre friction massage to scar tissue



Application of heat

The use of heat modalities have been shown to improve the flexibility of soft tissue, making them an effective method in preparing scar tissue for stretching and mobilisation. When using heat modalities it is important to understand the normal tissue temperatures found in the body. The temperature of the skin at its most superficial layer is approximately 30°C, muscle tissue 35°C, ligaments 36°C and intra-articular tissue 32°C (Hardy 1998). Physiological changes to these tissues can only occur when their temperatures are increased to over 40°C. Once collagen tissue temperature

is increased to over 40°C there is a 25% greater chance of elongation and stretch (LaBan, 1962).

It is the role of the therapist to decide which form of heat application and duration is appropriate for the goals of treatment. It is important to note that peak increases in temperature in the skin and subcutaneous tissue occur following 20 minutes of superficial heat application while muscles require 30 minutes (Abramson, Mitchell, Tuck, Bell & Zays, 1961). There are no proven benefits for continuing the application of heat for longer periods.

Given the size and volume of the hand, Paraffin wax and hot packs are effective in heating both the superficial and deeper tissue layers. Such modalities can also cover large surface areas and in the case of wax, allow the area to be passively stretched at the same time as being heated (Figure 8). Lehmann, Masock, Warren and Koblanski (1970) noted that simultaneous heat and stretch in rat tendons resulted in double the gains in elongation in half the time.

Figure 8 : Paraffin wax used in combination with Coban™ to combine heat and passive stretching



Application of conventional Ultrasound, especially at 1MHz and using the continuous mode produces thermal effect to a depth of approximately 5cm in soft tissues. Acoustic energy is absorbed as it penetrates the soft tissue, causing molecules to vibrate under repeated non interrupted cycles of compression waves (Bélanger, 2010). This causes an elevated level of micro friction between the molecules generating heat in the tissue.

From our experience and through patient feedback there is a correlation between the use of ultrasound therapy and improvements in scar tissue in terms of softening the tissue and increasing range of motion. It must be noted however, a study from Ward R. et al. (1994) examined the effects of passive stretching following continuous Ultrasound on scars as a result of burn injuries. This study concluded that there was no positive difference in range of motion in patients following continuous Ultrasound and stretching in comparison to placebo Ultrasound and passive stretching.

Compression

Compression causes a hypoxia to the applied area. This reduces the number of fibroblasts and collagen cohesions and increases the rate of the collagenase enzymes, which help reduce the ongoing production of collagen (Baisch & Riedel, 2006). Compression is effective in treating and preventing the growth of both hypertrophic, keloid and burn related scarring. Compression materials such as Elastomer (Figure 9) Digi Sleeve®, Coban™ (Figure 10), Co-flex® and gloves,

should be worn as close to 24 hours a day as possible and only removed when necessary, for example to complete mobilisation exercises or skin care.

Figure 9: Splinting using Elastomer Putty is also a favoured form of providing compression. For example, it may be used following Duypytrens release as it has the added benefit of being silicon while applying a passive stretch to the scar tissue.



Figure 10: Coban™ with cotton wool bandage

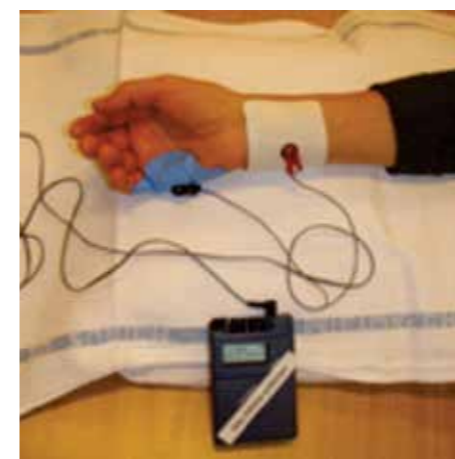


Iontophoresis

Iontophoresis delivers medicated and non medicated solutions to the skin (Bélanger 2010) (Figure 11). It is a non invasive method option for typically injected medicines (Waldner-Nilsson, 2009).

A study from Dardas et al (2014) assessed the effect of acetic acid on recalcitrant scarring. It has been shown to effectively remodel type 1 collagen in scar tissue, improving the overall function of the affected area by weakening the tissue and increasing its flexibility. The study concluded that following a period of iontophoresis therapy, participants did achieve an increase in total active motion. Walden Nilsson (2009) recommends that Iontophoresis therapy be completed at least 3 times a week.

Figure 11: Iontophoresis setup. Here buffered electrodes maintain the pH of the skin and increase the rate of penetration of the solution



Patient Education

To ensure that patients can successfully complete the scar management program independently, we have found it useful to provide both written information sheets as well as thorough home program training in the clinic. It is essential that patients understand:

- Correct scar management techniques

- Appropriate positioning and duration of splint wear
- Use of silicon- in particular application and hygiene
- Correct positioning and application of tapes

Knowledge and practice of a range of scar management techniques is an essential aspect of hand therapy. This knowledge allows therapist to remain flexible in their treatment approach, allowing for client centred therapy and best possible functional outcomes.

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Member Society Updates

JAPANESE SOCIETY FOR SURGERY OF THE HAND

1) President's Greetings

It is my great pleasure to introduce our society in the IFSSH ezine Society News. JSSH is one of the oldest hand surgery societies in the world and one of the eight founding member societies of the IFSSH. Our society has contributed internationally to the development of hand surgery and intends to do yet more from now on. The photo includes the members of the present board of directors. (Hiroshi Yajima M.D. & Ph.D., the 7th president of JSSH)



2) Foundation and development of JSSH

In 1956, Dr. Harry Miller from Pennsylvania visited Japan. He brought the film, "Tendon Repair", edited by Dr. Mason, and a letter from Dr. Bunnell which encouraged the launching of the Hand Society in Japan. In 1957, the Japanese Society for Surgery of the Hand (JSSH) was founded, and the secretariat was opened at Kyushu University. The 1st Annual Meeting was held on July 7, in Kobe City (president, Prof. Amako). The participants numbered only fifty, and discussed hand contracture and tendon repair. The proceedings were published under the title 'Basics of Hand Surgery'. With the effort of many senior hand pioneers, the JSSH has now grown to

3,557 regular members, approximately 14.3 % of whom are plastic surgeons. The annual meeting is regularly held every year. The 58th Annual Meeting was held in Shinjyuku, Tokyo pref (Congress President Prof. Nemoto), in April 2015. The participants totaled approximately 1,638, and 562 papers including poster presentations were discussed. As the Society grows, a stronger system is needed to manage it. Prof. Tamai was elected the first president of the JSSH in 1999. The JSSH organization has 1 president, 2 vice presidents, 9 directors, 2 auditors, and 233 councilors. Now the congress president, elected every year, is engaged in the management of the annual meeting. In 2007, the Qualified Hand Surgeon system was started, and

450 surgeons were registered as QHS-certified. Organizing international meetings is also an important task for the JSSH. The 3rd International Federation of Societies for Surgery of the Hand (IFSSH) Congress in 1986 was the first big international meeting hosted by the JSSH (president, Prof. Tajima). This international activity of the JSSH has been followed up with the 2nd International Symposium on the Wrist in 1991 (president, Prof. Miura), the 5th International Symposium on Congenital Differences of the Upper Limb in 2000 (president, Prof. Ogino), and the 5th Asian Pacific Federation of Societies for Surgery of the Hand (APFSSH) in 2005 (president, Prof. Ikuta). Dr. Yamauchi was elected as the President of the IFSSH in 1998.

Dr. Tamai was also elected as the President of the APFSSH in 2000. Then Dr. Beppu was also elected as the President of the APFSSH in 2012. Many senior Japanese hand surgeons were elected as "Pioneers of Hand Surgery" by the IFSSH. We congratulate the hand societies on their evolution and hope for an even closer relationship between the IFSSH and the JSSH.

3) 59th Annual Meeting of the JSSH

Date and time April 21-22, 2016
Place Hiroshima
President Professor. Takaya Mizuseki, Hiroshima Prefectural Rehabilitation Center
URL <http://www2.convention.co.jp/59jssh/english.html>

4) Secretariat for Japanese Society for Surgery of the Hand

Address c/o Congress Corporation, Kohsai-kaikan Building, 5-1 Kojimachi, Chiyoda-ku, Tokyo 102-8481, Japan
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URL <http://www.jssh.or.jp/>

KOREAN SOCIETY FOR SURGERY OF THE HAND

The Korean Society for Surgery of the Hand (KSSH) was established in 1982. The KSSH has successfully held international hand society meetings, such as the 4th congress of the Asian Pacific Federation of Societies for Surgery of the Hand (APFSSH) in 2002 and the 11th congress of the International Federation of Societies for Surgery of the Hand (IFSSH) in 2010. In addition, the 9th congress of World Society of Reconstructive Microsurgery (WSRM) will be held in Seoul on June 15-17, 2017, and we cordially invites you to join this meeting and to exchange your new opinions and great experiences on microsurgery field.

The KSSH started its hand surgery subspecialty board system in 2005, which is now in the right direction, producing the 12th subspecialty hand surgeons this year. Surgeons who have finished their orthopaedic, plastic or general surgery residency training for four years,

plus at least one year of hand surgery fellowship training, can apply for the hand surgery subspecialty examination to become a board-certified hand surgeon. Hand surgeons have to maintain a specified level of requirements (education, meeting attendance, or research) to renew the certificate every five years. Now there are about 250 board-certified subspecialty hand surgeons in Korea.

The annual congress of the KSSH takes place in November, when the autumn leaves are beautiful. At the recent one which was held on November 21, Professor Ulrich Mennen, the immediate past president of IFSSH, gave an invited lecture regarding thumb base osteoarthritis. A total of 68 oral presentations and 68 e-posters were presented at the last meeting. The 2016 KSSH annual congress will take place on November 11-12 in Seoul, chaired by professor Goo Hyun Baek. We now try to make this meeting more educational and comfortable for international



participants from nearby Asian countries.

Korean hand surgeons sincerely wish that this New Year becomes a very special one with health, happiness, prosperity, and peace for all members of the IFSSH and their families.

KUWAIT SOCIETY FOR SURGERY OF THE HAND

Kuwait is a small country in the Middle East on the Arabian gulf. The population is just over four million. Fifty percent are expatriates. We have a lot of unskilled labour, working with modern appliances but lacking safety measures. Hand surgery was started in Kuwait by the Dr. Kamal Helmy (deceased 1992) in the late seventies of the last century. He was frequently visited by eminent surgeons like Douglas Lamb, Pulvertaft, and the late Marko Godina. In 1992 a formal hand surgery unit

was established by the late Dr. Fouad Roshdy, Husam Basheer, and Kamal El Helw. During later years the department grew in number as the population of Kuwait increased. Now in 2015 we have 16 trained hand surgeons. They excel in all sorts of hand surgeries. In Kuwait there is one major orthopaedic hospital and four other peripheral departments. Hand surgery is stationed in Al Razi Hospital which is the main orthopaedic hospital and serves all of Kuwait - both old and emergency cases. In addition we have co-operation with plastic surgeons from a nearby hospital for cases that require major flap coverage.

The Kuwait Society for surgery of the Hand was founded in 2002. We run monthly meetings and local conferences are held regularly to improve the professional skills of the surgeons along with the annual activities. We continued

the tradition of inviting eminent surgeons to our hospital 3-4 times a year. These visits help in maintaining our connections with the world and expose our doctors to different experiences while seeing the experts handling our difficult cases.

We run an annual training course in wrist arthroscopy, another microsurgery training course over a day or two.

We cooperate with the Kuwait Institute for Scientific Research (KISR) for the manufacturing and development of external fixation devices that require special specifications. These are used locally and many were donated to areas of need overseas.

We are working on a plan to start a fellowship in hand and peripheral surgery in cooperation with other neighbouring gulf states to train more local doctors. Relatively we run a small service but hopefully we are on the right track to serve our population.

Dr Husam Basheer, IFSSH delegate



Participants and organizers of the VIII Congress of the Polish Hand Surgery Society in Gdansk, President Tomasz Mazurek (Figure 1a bottom left)

POLISH SOCIETY FOR SURGERY OF THE HAND (POLSKIE TOWARZYSTWO CHIRURGII RĘKI)

The past year was fruitful for Polish Hand Surgery. As happens every year, many meetings and symposia were organized to develop knowledge in hand surgery among orthopedic, plastic and general surgeons focused on this area.

The most important event was the VIII Congress of the Polish Hand Surgery Society in Gdansk. The scientific level was high and many topics were discussed by Polish surgeons and international guests. Our Society created the honorary title "Meritorious for Hand Surgery" and the first three awardees are Władysław Manikowski, Alfred Ożga and Antoni Hlavaty. The titles were announced during the gala. During the Congress we also held the elections, with Tomasz Mazurek now becoming the

President of Polish Society for Surgery of the Hand.

Besides many other activities, the 8th International Poznań Course in Upper Extremity Surgery was organised. This time the Course gathered 300 participants and 30 lecturers covering hand surgery topics including tendons, arthritis, arthroscopy and trauma. The schedule provides comprehensive instructional lecture as well as workshops focused on practical skills. Alongside the course was the poster session of the Hand Surgery Section of Polish Society of Orthopedics and Traumatology and cadaver course.

Leszek Romanowski and Piotr Czarnecki, Poland Society for Surgery of the Hand



NEW ZEALAND HAND SURGERY SOCIETY

The New Zealand Society has become more active in recent years beginning with a meeting in Rarotonga Cook Islands in 2010. At that meeting, convened by Dr Karen Smith, with guest speaker Randy Bindra, it was decided to have scientific meetings every two years. Subsequently we have had two further excellent meetings in Queenstown, a resort in the South Island - one in 2012, with Amit Gupta the international guest, and the latest meeting in 2014. The 2014 meeting proved to be the most successful yet as it coincided with the New Zealand hand therapy meeting and the New Zealand Orthopaedic Association's continuing orthopaedic education program. Greg Bain and Don Lalonde were our guests and gave tremendous insight into biomechanical thinking and wide awake hand surgery. The meeting also announced the retirement of Professor Alistair Rothwell and for his mammoth contribution to Tetraplegia, it was decided by the executive to create an honorary title for the guest speaker at our biennial meeting. Greg Bain thus gave the inaugural "Alistair Rothwell International guest lecture", giving a moving memoir of how Prof Rothwell has helped mentor him over many years. Also created was the Dr Chris Bossley award for the best trainee paper at the meeting.

Karen Smith has been our President for the past five years and in that time the society has gone from strength to strength. We now have over forty members, both active plastic and orthopaedic surgeons, in our society and have linked in with Australia and their fellowship training program. We have active involvement again in the IFSSH and are looking forward to two major meetings in 2016: our biennial meeting in Queenstown in July with Dr David Slutsky, the Alistair Rothwell guest; and also the triennial IFSSH meeting in Argentina in October. As a society, we are most grateful to Karen for her guidance and leadership and for all the international guests and their contribution to our society. We would like to invite one and all to New Zealand for our meeting later this year.

Michael Boland, Secretary.



Part of the Organising Committee of the 10th APFSSH from L to R (Chuah CK, Palani R, Moroe Beppu, S. Roohi W, Shalimar A, Ruban S.) with the Honorable Datuk Dr. S. Subramaniam - Minister of Health, Malaysia (centre).

MALAYSIAN SOCIETY OF SURGERY OF THE HAND

From the Desk of Past President

Malaysia, with great trepidation, hosted the 10th APFSSH congress (and 6th APFSHT) in Kuala Lumpur from 2nd to the 4th of October 2014. It was an exciting event with plenty of lively discussions, lectures, debates, good food and entertainment as well. Great speakers from around the world graced our shores and were all very accommodating, allowing a relatively reduced-stress environment. I would like to take this opportunity to thank these wonderful speakers (all 106 of them) as well as the 640 participants for making this such a lively and enjoyable event. I would also like to especially mention my colleagues from the 2001-2003 years in Louisville who took time out from their schedules to come to Kuala Lumpur, Malaysia – I was deeply touched.

It is with great sadness today I heard that one of our beloved

Professors passed away on the 6th of January 2016 in Louisville, Kentucky – Professor Robert D Acland – a great inspiration, wonderful teacher and innovator, who has touched thousands of

lives. We will indeed miss you, Sir. I am writing this now for in a years' time the 11th Congress would be held in Cebu, the Philippines in February 2017, and I sincerely

hope they enjoy the organisation, the rekindling of contacts and the camaraderie that we felt in 2014. Good Luck and see you soon!

IFSHT: UPDATE

SPOTLIGHT ON IFSHT MEMBER SOCIETY: COLOMBIA

The Colombian Association of Hand Therapists (ASCOTEMA) consists of occupational and physical therapists specialized in hand and upper limb rehabilitation. Created in 2004, ASCOTEMA joined IFSHT in 2010. The 7th ASCOTEMA National Congress in August 2015 included topics on proprioceptive training and reeducation, sports injuries and musician's injuries. Two therapists from New York, Olga Lucia Hincapié and April O'Connell, joined 15 national speakers. New board members for 2015-2017 (below) were appointed.



L to R: Camilo Zapata, Carolina Cardona, Paola Salazar, Adriana Navarrete, Fiorella Sighinolfi, Carolina Molano, Carmen Lucia Rodriguez, Adíela Estrada, Amparo Ardila, Ángela Velásquez, Ivonne Quintero, Xiomara Flores

2016 IFSSH/IFSHT CONGRESS SITE VISIT

Planning for the 2016 IFSHT Triennial Congress is proceeding at full throttle. IFSSH and IFSHT recently completed the official site visit of the congress venue in Buenos Aires and met with the local planning committees. The joint congress will be held at the Hilton Hotel in the riverside district Puerto Madero, Buenos Aires. Buenos Aires is a safe and lively city, with beautiful architecture and many cultural attractions.



2016 IFSSH-IFSHT Congress site visit with local organizing committee (LOC) in Buenos Aires, Argentina. L to R: Gabriel Clembosky (LOC), Sarah Ewald (IFSHT), Marc Garcia-Elias (IFSSH), Beatriz Pizo (LOC), Eduardo Zancolli (LOC), Adriana Pernoff (LOC)

The preliminary program for the congress is available at <http://www.ifssh-ifsht2016.com>. Registration for the Congress opened in December 2015, with abstract submission open until 28 February 2016. Why not submit an abstract and share your knowledge at the Congress? Or just come along and gather some new ideas for your daily practice as a hand therapist. **We hope to see you in Buenos Aires!**

NOMINATIONS FOR IFSHT LEADERSHIP

If you are a therapist from one of IFSHT's full member organisations and are interested in joining the IFSHT Executive Committee, please review the descriptions of each office (<http://www.ifsht.org/page/ifsht-job-descriptions>). Nominations are open until April 2016. Ask your Association to nominate you for a position on the 2016-19 IFSHT executive committee.



IFSSH EZINE

Issue 20 of the IFSSH Ezine included an article on an evidence-based approach to conservative management of CMC OA, by Anne Wajon from Australia. It can be downloaded from IFSSH at: <http://www.ifssh.info/ezine.html>.

HAND THERAPISTS WORKING ABROAD

Suzanne Caragianis (Australia) has been involved in developing hand therapy in the Kingdom of Bhutan since 2008. By setting up a continuing education program and providing donated assessment and splinting equipment, she has helped established a sustainable hand program to improve hand care for the people of Bhutan. The two hand clinics in Thimphu and Mongar have allowed many hundreds of patients to have the best non-surgical and post-operative care. Ms. Caragianis acknowledges the support of IFSHT in sponsoring a Bhutanese physiotherapy technician to attend the 2013 Triennial Congress in India. If you are interested in applying for a travel grant to attend the IFSHT Congress in October 2016, go to:



<http://www.ifsht.org/page/ifshtifssh-triennial-congress-travel-grant-0>. Tshering Forji (left), Physiotherapy Technician and Suzanne Caragianis with patient in Bhutan

IMPORTANT DATES FOR IFSHT 2016

- Registration/abstract submission opens Dec 2015.
- Abstract submission closes 28 Feb 2016.

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

ROMANIAN SOCIETY FOR SURGERY OF THE HAND

The year 2015 was a good one for our Society.

First, our Society was invited to be the guest society at the 2017 Annual Meeting of the American Association of Hand Surgeons. Then, in April 2017, the AAHS will be invited in Cluj Napoca, Romania to co-organize with the Romanian Society for Surgery of the Hand (RSSH) a course before our biannual congress.

In April 2015 we organized the Xth RSSH Congress combined with XIth Congress of the Romanian Society for Reconstructive Microsurgery (RSRM), with the participation of foreign Faculty from Italy and Moldova Republic, with more than 250 surgeons participating.

Because we intend to perform as soon as possible the first hand transplant in Romania, we organized in July 2015 a Hand Transplant Symposium, in which

we were honored to have as Faculty



Figure 1: Residents doing tendon sutures on pigs' legs

Maria Siemionow and Vlodek Siemionow from USA, and Riccardo Giunta from Germany.

In addition, our society organized two Hand Surgery Courses and workshops, dedicated mainly to tendon sutures and local flaps on the upper limb. Also, in association with RSRM, our society organized basic and advanced courses in microsurgery, and Flaps Dissection Courses in living tissues (pigs).

The RSSH is preparing some very interesting courses and workshops with international participation in 2016. We have already started

the preparations for the national congress, which will be held in April 2017.

Alexandru Georgescu, M.D., PhD
President of the Romanian Society for Surgery of the Hand
Delegate of RSSH to IFSSH

ITALIAN SOCIETY FOR THE SURGERY OF THE HAND (SOCIETÀ ITALIANA DI CHIRURGIA DELLA MANO)

The Origin

The first Italian Department for the care of the lesions of the hand was opened at the Centro Traumatologico Ortopedico INAIL in Milan and was directed by Aldo De Negri (1910-1996). In 1959 on October 24, the Annual Meeting of the Italian Orthopedic Society was taking place in Rome. During the meeting, Augusto Bonola and Oscar Scaglietti proposed to dedicate a branch of the Orthopedic Society to the Hand Surgery. Augusto Bonola (1906-1976) was at that time one of the first Italian Pioneers in Hand Surgery. His first clinical and surgical experience was in Bologna at the Rizzoli Institute, under the guide of Vittorio Putti and Francesco Delitala.

During the 2nd world war, his experience was growing even more and he realized one of the main teachings in Hand Surgery: the importance of the skin cover

in difficult open wounds in order to avoid macro amputations. After the war Augusto Bonola became Professor in Orthopedic Surgery at the University of Modena where he created a centre for Hand Surgery along with the first Hand Surgery training program in Europe.

In 1962 in Florence during the first National Meeting entirely dedicated to the Hand, the Italian Society for the Surgery of the Hand (SICM: Società Italiana di Chirurgia della Mano) was founded. The Founding Members were: Augusto Bonola, Giorgio Brunelli, Aldo de Negri, Leonardo Gui, Germano Mancini, Umberto Mangini, Ezio Morelli and Filippo Perricone.

The Present

The President-elect for the 2015-17 biennium is Dr Roberto Adani, Chief of the Hand and Microsurgery Department in

Modena. The new council of SICM has been elected in October 2015 (Fig 1).

Today the Italian Society for the Surgery of the Hand includes 12 Honorary Members, 836 full registered members, and 40 young members. The majority of the Italian members are Orthopedic Surgeons while Plastic Surgeons are a substantial minority.

The Society Secretariat is based at: **Italian Society for Surgery of the Hand**

c/o PLS - Via della Mattonaia, 17 - 50121 Firenze FI

Tel. 05524621 Fax. 0552462270
Email: sicm@promoleader.com
Web Site: <http://www.sicm.it>

The Society Journal is the "Chirurgia della Mano" that is the official Journal since 1963 (C.G. Edizioni Medico Scientifiche s.r.l.; <http://www.cgems.it/inside3>).

[aspix?ch=i.riv&idCat=1.1.2.5](http://www.sicm.it/inside3.aspx?ch=i.riv&idCat=1.1.2.5)).

Training and formation of surgeons

In Italy, surgeons aspiring to become Hand Surgeons should first join a full training program in Orthopedic Surgery or Plastic Surgery (5 years). After their registration in the Specialist Register, several fellowships, masters and courses are available patronized by the SICM. The European Federation of Societies for Surgery of the Hand holds a Diploma examination at the time of their annual congress (www.fessh.com).

SICM has a particular interest in training programs not only for young surgeons. For young surgeons, during the residency program, the SICM organizes three main courses:

- anatomy and surgery with cadaver dissection course organized into three modules



Figure 2: Alexandru Georgescu with Maria Siemionow and Riccardo Giunta, opening the First Hand Transplant Symposium in Cluj Napoca, Romania



Fig 1: The new elect council member of the Italian Society for Surgery of the Hand 2015-2017.

(one week each – anatomy, orthopaedic/hand surgery, plastic/hand surgery)

- advanced course in microsurgery - organized in collaboration with the Societies of Microsurgery and Plastic Surgery - with 120 hours of practice - again in three weeks during the year
- some Hand and Microsurgery fellowship of 1 year are available in recognized Hand Surgery Centers.

Tendon transfers) with great success (Fig 2,3). Next year the theme will be on the hand - tendon repair and arthroplasty - and on the reconstruction of the elbow. The programs are available via www.sicm.it.

Every year a National Congress is held in a Center of Hand Surgery and in 2016 this will be in Palermo. The topic will be "Compression Syndrome of the Upper Limb".

All information is available on the SICM website: <http://www.sicm.it>.

Pierluigi Tos MD, PhD
IFSSH Delegate of The Italian Society for Surgery of the Hand (SICM)
pierluigi.tos@unito.it



Fig 2: Organizers of the 2015 dissection course on nerve compressions and complications: Roberto Adani, Nicola Felici, Pierluigi Tos with Donald Sammut (second from the left).



Fig. 3 Participants at the most recent dissection course on PNS held in Arezzo in December 2015

UPDATE



American Society for Surgery of the Hand

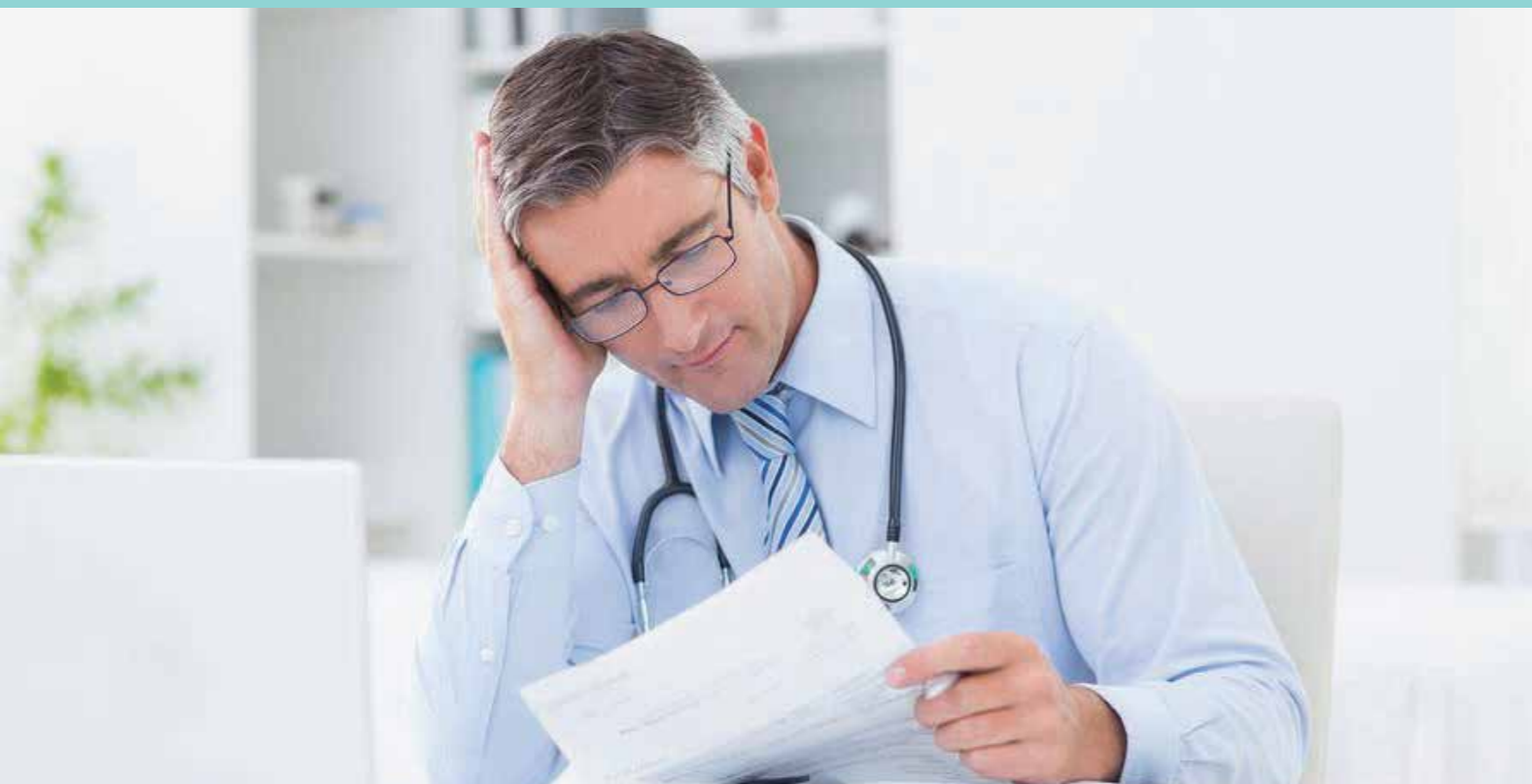
ASSH held its 70th Annual Meeting in Seattle in September. The event was a great success with 2,727 attendees. ASSH introduced new innovations like interactive e-Posters and the Hand-e Video Theater, which provided 46 new videos that are now on the [Hand-e platform](#). The 71st Annual Meeting will take place in Austin, Texas from 29 September through 1 October 2016. Please [visit our website for more information](#).



The ASSH International Member application **deadline has been extended to 15 March 2016**. ASSH is pleased to invite all hand surgeons to apply to join our membership ranks. As an International Member you will receive: a subscription to the Journal of Hand Surgery; access to Hand-e (a comprehensive online learning resource); discounts on books, courses, and our Annual Meeting; wonderful opportunities for networking and collaboration; subscriptions to all ASSH newsletters; and more. [Learn more, and apply online](#). If you have questions or need assistance completing an application, please email membership@assh.org.

One of ASSH's greatest study tools is now available to international hand surgeons at a discounted price. The annual Self-Assessment Exam is a helpful on-demand study tool in question/answer format that helps you stay on top of all the latest materials in hand surgery. The \$195 USD rate for international surgeons is the same discount given to ASSH Members. The deadline to register is 15 April. [Learn more on our website](#).

Finally, we continue to add new material to [Hand-e](#). ASSH offers discounted access for many international surgeons, some can even gain access for free. Members have free access as well. It is an incredible resource, full of videos from our meetings, technique videos and exclusive articles. Email feedback@assh.org with questions.



Evaluation of the **injured** hand *in a nutshell*

Luc De Smet MD, PhD

University hospitals Leuven, Belgium

Hand injuries are frequent, often minor, and occasionally very severe. It is often the junior resident who does the primary evaluation, the treatment and the reporting.

Here are some guide lines which could help in the evaluation and management.

1. LISTEN to the patient, then **LOOK** at the whole hand and the whole patient

- Mechanism of accident
- Allergies, medications and co-morbidity

- previous (hand) injuries
- Expectations of the patient, special skills, professional needs
- Hand dominance is over-estimated (indications and treatment is similar for both hands)

2. TURN AWAY your head from the screen and papers towards the patient

- Powerful imaging is not a substitute for good clinical exam
- Other physicians' opinion/findings are important, but the patient is the main player

3. ORDER radiographs **AFTER** seeing the patient

- Assumed pathology requires specific radiographic techniques
- Preop planning requires good radiographs

4. DO NOT EXPLORE WOUNDS IN BAD CONDITIONS

- Looking at a wound is an additional risk factor for further damage and infection
- It is painful and causes distress
- Cleaning the wound is essential but should not be painful. "Only put

into a wound what you can tolerate in your eye"

- Evaluate the skin: crushed, contaminated, defect

5. Sensibility is tested for **EACH** hemipulpa

- A yes/no feeling is often enough

6. Tendons are tested by **MOTION**, not just by looking

- Flexion and extension of each joint distal to the injury should be checked

7. Make notes, drawings or take photo

8. Do not trust ultrasound

- A powerful tool but not in an emergency setting for hand injuries

9. "If in doubt, there is no doubt: go to the OR"

- See (4)
- Especially in children and unconscious patients
- Adequate light, bloodless field, good anaesthesia, adequate material, skilled surgeon
- No place for trial and error; training is done in cadaver labs not in the OR or ER

10. If the injury is not an emergency, and the examination is unsatisfactory/inconclusive, schedule a follow-up appointment

- Lesions picked up within 48 hours are usually treatable with similar results
- Testing sensibility, motion and stability of joint is easier when the pain has subsided

11. Be aware of the "Cinderella pathology" (minor injury, major consequence)

- High pressure injection injury
- Bite/fight injury
- Occult fractures (scaphoid) and ligament lesions
- Foreign object
- Small wounds with perforation of joints and flexor tendon sheaths are prone to infection
- Ring avulsion injury: sometimes with good arterial but no venous return

of bacteria and fungi. Antibiotics can cause selection. The adagio "if it does not help, it does not cause harm" is not applicable in hand injuries

14. Respect the patient (and his peers). His/hers opinion is valuable. If not drunk, drugged or mentally sick, the final decision for treatment is his/hers.

15. Protect the patient, yourself and the others. Anxious, psychiatric, aggressive patients can do harm to themselves and others

16. No job is finished until the paper work is done, but is not the most important issue; remember that the only urgent paper is the one you use on the toilet

“If in doubt, there is no doubt: go to the OR”

12. What is urgent? BLOOD: "too much coming out, not enough going in"

- Open lesion with arterial bleeding, amputations, patients with anticoagulants
- Vascular lesions (see also (11 f)); capillary refills not to be trusted: an injured finger may have an increased venous pressure in the pulp which masks a good capillary refill; I prefer the turgor of the pulp. Otherwise see (8)

13. Antibiotics are not an alternative to good cleaning; the hand is a vector

Eastern European Course on Hand Surgery: Hand Reconstruction in Trauma and Rheumatoid Arthritis

4-6 September 2015, Hajdúszoboszló, Hungary

The care for rheumatoid arthritis has changed since the introduction of highly effective disease modifying drugs such as the biologics that were designed to target inflammatory mediators for this disease. Two years ago, Dr. Daniel Herren and Kevin Chung conceived the idea of teaching a course focused on the care for the rheumatoid hand for surgeons in Eastern European countries, a region that cannot afford the use of these highly expensive biologics. In Eastern Europe, rheumatoid hand deformities are common despite the best efforts of surgeons because understanding of the treatment of rheumatoid hand deformities is still in its infancy.

With the collaboration of the IFSSH, FESSH, and ERASS including the support of the companies Synthes and Medartis, a highly successful course was held in Hajdúszoboszló with the guidance of Dr. Zsolt Szabó. Ninety three registrants attended a three day course. Half of the participants received financial

support including free registration, accommodation and food. The meeting's highlight was a cadaver course on the first day in the beautiful facility at the University of Debrecen. Prominent surgeons with an international reputation on rheumatoid hand surgery participated in this course including Dr. Zsolt Szabó, Dr. Alfredo Olazabal, Dr. Philippe Bellemère, Dr. Massimo Ceruso and Dr. Renato Fricker. The procedures demonstrated ranged from MCP joint fusion of the thumb, metacarpophalangeal joint arthroplasty as well as PIP implant arthroplasty. Participants

interacted with the faculty from the auditorium by seeing live-feeds from the cadaver lab and moderated by Dr. Zsolt Szabó.

The remaining days were also highly successful by having presentations on common rheumatoid themes for the elbow, wrist, and hand. Concepts discussed include the treatment of swan-neck and boutonnière deformity, arthroplasty and fusion procedures, and elbow reconstruction. Additionally, the participants were instructed in the medical treatment of rheumatoid arthritis and outcomes research as well as the appropriate



The faculty of the Hungary course 2015: From left to right: Renato Fricker, Philippe Bellemère, Daniel Herren, Kevin Chung, Zsolt Szabó and Alfredo Olazabal (missing Massimo Ceruso)



Faculty and participants of the 2015 Hungary course

patient selection for surgery. The participants hailed from more than a dozen countries including Romania, Poland, Lithuania, Latvia, Russia, Czech Republic and Slovakia. At the end of the course, certificates were given to the participants signed by the course Chairmen.

Dr Herren and I are gratified by the generous support from IFSSH, FESSH, ERASS and as well of Synthes and Medartis, which also provided the instruments and implants for the demonstrations. The outstanding coordination of the

course by staff Krisztina Szigedi and Dr. Zsolt Szabó facilitated a wonderful venue in a cost effective and highly efficient manner to disseminate the principles of rheumatoid hand surgery for much needed care in Eastern Europe. We as Chairmen are most delighted of the success of this course and the interest it created. Many contacts were made and ideas exchanged. The vision to address a gap in knowledge and much needed training in Eastern Europe has been fulfilled. Until such time when rheumatoid arthritis is cured, hand surgeons will continue to play

a prominent role in ameliorating the devastation of rheumatoid arthritis and improving the quality of life for patients who can carry out activities of daily living and also be productive contributing members of society.

Respectfully submitted,
Daniel Herren and Kevin C. Chung



Kevin Chung and Daniel Herren while teaching during the surgical demonstrations



Kevin Chung demonstrating MP joint arthroplasty



Zsolt Szabó during the surgical demonstration in a well equipped environment

HAND CLINICS**(FEBRUARY-2016 VOLUME 32, ISSUE 1)**

- Pain Management
Catherine Curtin
- Pain and Hand Function
Nicholas Howland, Mariela Lopez, Andrew Y. Zhang
- Self-Report Measures of Hand Pain Intensity
Elena Castarlenas, Rocío de la Vega, Mark P. Jensen, Jordi Miró
- Pain Examination and Diagnosis
Catherine Curtin
- Factors Associated with Greater Pain Intensity
Mariano E. Menendez, David Ring
- Pain Psychology and Pain Catastrophizing in the Perioperative Setting
Beth D. Darnall
- New Concepts in Complex Regional Pain Syndrome
Maral Tajerian, John David Clark
- Pharmacologic Management of Upper Extremity Chronic Nerve Pain
Ian Carroll
- Hand Therapy Treatment
Susan W. Stralka
- Surgical Treatment of Upper Extremity Pain
Arnold Lee Dellon

- The Proper Use of Neurostimulation for Hand Pain
Jason E. Pope, David Provenzano, Porter McRoberts, Timothy Deer

- Future Directions for Pain Management
Sean Mackey

JOURNAL OF HAND SURGERY (EUROPEAN)**(JANUARY 2016)**

- Functional kinematics of the wrist
M. J. Rainbow, A. L. Wolff, J. J. Crisco, and S. W. Wolfe
- Imaging in carpal instability
N. K. Ramamurthy, A. J. Chojnowski, and A. P. Toms
- The role of arthroscopy in carpal instability
T. R. Lindau
- Outcome of arthroscopic reduction association of the scapholunate joint
S. M. Koehler, S. M. Guerra, J. M. Kim, S. Sakamoto, A. J. Lovy, and M. R. Hausman
- Mid-term results of ligament tenodesis in treatment of scapholunate dissociation: a retrospective study of 20 patients
A. Elgammal and B. Lukas

- An arthroscopic-assisted minimal invasive method for the reconstruction of the scapho-lunate ligament using a bone–ligament–bone graft
N. Dellarosa, H. Ozben, M. Abate, A. Russomando, G. Petrella, and A. Landi

- Management of lunotriquetral instability: a review of the literature
T. C. van de Grift and M. J. P. F. Ritt

- Midcarpal instability
D. G. Hargreaves

- The role of proprioception and neuromuscular stability in carpal instabilities
E. Hagert, A. Lluch, and S. Rein

- Conservative management of midcarpal instability
C. Harwood and L. Turner

JOURNAL OF HAND SURGERY (AMERICAN)**(JANUARY 2016)**

- The Effect of Ex Situ Perfusion in a Swine Limb Vascularized Composite Tissue Allograft on Survival up to 24 Hours
Kagan Ozer, Alvaro Rojas-Pena, Christopher L. Mendias, Benjamin S. Bryner, Cory Toomasian, and Robert H. Bartlett

- Reappraisal of Clinical Deficits Following High Median Nerve Injuries
Jayme Augusto Bertelli, Francisco Soldado, Vera Lúcia Mendes Lehn, and Marcos F. Ghizoni

- A Cadaver Study of Median-to-Radial Nerve Transfer for Radial Nerve Injuries
Koji Sukegawa, Takane Suzuki, Yasufumi Ogawa, Tomoko Kobayashi, Yusuke Matsuura, and Kazuki Kuniyoshi

- Motor Nerve Recovery in a Rabbit Model: Description and Validation of a Noninvasive Ultrasound Technique
Liselotte F. Bulstra, Caroline A. Hundepool, Patricia F. Friedrich, Tim H. J. Nijhuis, Allen T. Bishop, and Alexander Y. Shin

- Trapeziectomy Arthroplasty With Suture Suspension: Short- to Medium-Term Outcomes From a Single-Surgeon Experience
Pat B. Roman, Joshua D. Linnell, and John B. Moore

- Direct Radiological Visualization of Loading on Four Flexor Tendon Repair Suture Configurations
Xiaoke Dong, Min He, Christopher Fang, Teemu Karjalainen, and Sandeep Jacob Sebastin

- Complications Following Partial and Total Wrist Arthroplasty: A Single-Center Retrospective Review
Michael P. Gaspar, Jesse Lou, Patrick M. Kane, Sidney M. Jacoby, A. Lee Osterman, and Randall W. Culp

- Proximal Pole Scaphoid Fractures: A Computed Tomographic Assessment of Outcomes
Ruby Grewal, Kristina Lutz, Joy C. MacDermid, and Nina Suh

- Computer-Assisted 3-Dimensional Reconstructions of Scaphoid Fractures and Nonunions With and Without the Use of Patient-Specific Guides: Early Clinical Outcomes and Postoperative Assessments of Reconstruction Accuracy
Andreas Schweizer, Flavien Mauler, Lazaros Vlachopoulos, Ladislav Nagy, and Philipp Fürnstahl
- Hand Amputations at the Radiocarpal Level With Proximal Neuromuscular Avulsion
Pedro C. Cavadas, Alessandro Thione, and Carlos Rubí
- Vascularized Composite Tissue Spare Part Transfer for Central Hand Defect Reconstruction: Case Report
Jessica Billig, Shepard P. Johnson, Takeshi Ogawa, and Kevin C. Chung
- Capnocytophaga canimorsus Sepsis Following a Minor Dog Bite to the Finger: Case Report
Nicolas J. Dedy, Sarah Coghill, Nanda Kumar S. Chandrashekar, and Randy R. Bindra
- Innervation of the Elbow Joint: A Cadaveric Study
Ali Nourbakhsh, Adam G. Hirschfeld, Daniel R. Schlatterer, Steven M. Kane, and Gary M. Lourie
- The Effect of Treatment on Stereognosis in Children With Hemiplegic Cerebral Palsy
Erica Petersen, Wendy Tomhave, Julie Agel, Anita Bagley, Michelle James, and Ann Van Heest
Commentary on "The Effect of Treatment on Stereognosis in Children With Hemiplegic Cerebral Palsy"
Mitchel Seruya
- Online Patient Ratings of Hand Surgeons
Samir K. Trehan, Christopher J. DeFrancesco, Joseph T. Nguyen, Resmi A. Charalel, and Aaron Daluiski

- Physician-Rating Web Sites: Ethical Implications
Julie Balch Samora, Scott D. Lifchez, and Philip E. Blazar, the American Society for Surgery of the Hand Ethics and Professionalism Committee
Commentary on "Physician-Rating Web Sites: Ethical Implications"
Megan L. Ranney and Clayton A. Peimer
- The Hands in Art: Hands on 50 Pence British Coins
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- The optimization of peripheral nerve recovery using cortical reorganization techniques: A retrospective study of wrist level nerve repairs
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- Effect of wrist and interphalangeal thumb movement on zone T2 flexor pollicis longus tendon tension in a human cadaver model
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- A new method for measuring forearm rotation using a modified finger goniometer
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- Self-regulated frequent power pinch exercises: A non-orthotic technique for the treatment of old mallet deformity
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- Treatment of Chronic Scapholunate Ligament Injury
Nakamura, Toshiyasu

- Outcomes of Capitohamate Bone-Ligament-Bone Grafts for Scapholunate Injury
van Kampen, Robert J.; Bayne, Christopher O.; Moran, Steven L.; Berger, Richard A.

- A New Technique for Volar Capsulodesis for Isolated Palmar Scapholunate Interosseous Ligament Injuries: A Cadaveric Study and Case Report
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- Cable-Augmented, Quad Ligament Tenodesis Scapholunate Reconstruction
Bain, Gregory I.; Watts, Adam C.; McLean, James; Lee, Yu C.; Eng, Kevin

- Arthroscopic-Assisted Combined Dorsal and Volar Scapholunate Ligament Reconstruction with Tendon Graft for Chronic SL Instability
Ho, Pak-cheong; Wong, Clara Wing-yee; Tse, Wing-lim

- Reconstruction of the Scapholunate Ligament Using Capitohamate Bone-Ligament-Bone
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- Bilateral Second Carpal Row Duplication Associated with Multiple Epiphyseal Dysplasia
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- Osteoid Osteoma of the Ulnar Head—An Uncommon Cause of Ulnar Wrist Pain
Valle, Pablo; Rolland, Raphael; Chammas, Michel

- The Missed Scaphoid Fracture—Outcomes of Delayed Cast Treatment
Grewal, Ruby; Suh, Nina; MacDermid, Joy C.

- Altered Innervation Pattern in Ligaments of Patients with Basal Thumb Arthritis
Ludwig, Cassie A.; Mobargha, Nathalie; Okogbaa, Janet; Hagert, Elisabet; Ladd, Amy L.

- Volar, Intramedullary, and Percutaneous Fixation of Distal Radius Fractures
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- Combined Treatment of Wrist and Trapeziometacarpal Joint Arthritis
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- The Unstable Distal Radius Fracture—How Do We Define It? A Systematic Review
Walenkamp, Monique M. J.; Vos, Lara M.; Strackee, Simon D.; Goslings, J. Carel; Schep, Niels W. L.

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