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ezine ifssh

CONNECTING OUR GLOBAL HAND SURGERY FAMILY

SHARE SECTION

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HAND THERAPY

SUPPORTING PATIENT-CENTERED CARE WITH THE USE OF AN OUTCOMES DASHBOARD

John Hunter looking at the 2022 IFSSH Fellows

HAND SURGERY: SHOULD IT BE A SEPARATE SPECIALTY?

EVIDENCE-BASED, EMINENCE-BASED, HYPOTHESIS-BASED, OR WRONG INFORMATION-BASED PRACTICE?

With thanks for your contribution and participation

The Executive Committee of the International Federation of Societies for Surgery of the Hand (IFSSH) is grateful for the opportunity to reconnect in person with colleagues from around the globe in 2022, in particular at the London Triennial Congress. We thank all involved for providing a wonderful meeting at which hand surgeons could further their education, share global knowledge, nurture the next generation, and make new memories with international friends.

We extend our special thanks to the IFSSH Delegates for their continued support throughout the year, and wish all hand surgeons throughout the world all the very best for 2023.

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contents

"Hand-care should be part of Primary Healthcare"

As medical knowledge expands at an ever increasing rate, and with it diagnostic tools become more sophisticated and accurate, sub-specialisation becomes necessary due to the compounding complexity and technical expertise required to practise in any given field.

Despite incredible advancements in healthcare, however, the majority of our human race, consisting of over 8 billion individuals, still doesn't have access to the most essential healthcare services.

Many nations, as well as the WHO, are desperately promoting universal health coverage in attempts to solve healthcare inequalities.

It could be considered inappropriate when healthcare systems offer state-of-the-art services while basic primary healthcare for all remains unachievable.

In this issue of the IFSSH Ezine, an excellent article 'Hand Surgery: should it be a separate specialty?' by Wee Lam and Daniel Herren (p14-19) summarises five articles from the JHS(E) 47E; 6; June 2022, and discusses the pros and cons of training in a sub-speciality such as Hand Surgery.

If a country has adequate primary healthcare for all its citizens, pushing the boundaries of healthcare certainly seems to be appropriate, and leads the way to further advancements in healthcare.

Where basic healthcare is lacking, it would also be appropriate to teach all primary healthcare workers (family physicians and nursing professionals, among others) how to manage hand conditions correctly as part of essential medical services.

The point therefore is that the training of Hand Surgeons is unquestionably valuable, but teaching **frontline healthcare workers how to manage hand conditions properly** might be of even more value. This will notably reduce later complications, loss of function and permanent disability.

Management of common hand conditions and injuries should be part of Primary Healthcare.

Enjoy your work.

ULRICH MENNEN
Editor

President's Message

The world is an amazingly diverse place with eight billion people, almost two hundred countries, hundreds of ethnicities, and many religions. The hopes, fears and aspirations of our fellow men and women are moulded by local tradition, history, geography, and socio-economic factors.

This diversity is associated with shared goals as well as unshared goals that can lead to competition and strife.

As I reflected on this, it dawned on me that the International Federation of Societies for Surgery of the Hand is a very unique organization in that while we celebrate our diversity, the Member Societies and their members share a common vision and goal. And that common vision and goal is the care of our patients.

By participating in and supporting the IFSSH and its education programs and grants, the IFSSH Member Societies transcend their history, traditions, geography, and socio-economic status in order to advance the hand health of the world.

How noble is that!

Thank you!

DAN NAGLE
President: IFSSH

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Tamrin Hansen
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Message from the Secretary-General:

Message from the Secretary-General

Welcome to 2023. Despite political and financial challenges for nations around the world, our International Federation continues to grow and thrive. Underpinning this is the thorough revision of our bylaws - thanks to our President Dan Nagle who led this project for us with countless hours of meticulous attention to fine detail. The next crucial stage of development, especially in our digital world, is our communications output - thanks to Jin Bo Tang, Ulrich Mennen and our South American Member-at-Large Aida Garcia Gomez.

Now the world is no longer constrained by Covid rules, we can travel and meet and share, both professionally and personally. We look forward to seeing the programmes develop for our new Mid-term Course in Ecuador in 2024 and the Triennial Congress in Washington D.C. in 2025.

We have had enquiries for new national Hand Surgery societies to join us which, subject to the membership criteria, will expand our community and reach even further.

We continue to get requests for funding various educational projects; we should now be proactively expanding our revenue base so that even more work can be funded to the benefit of hand surgeons across the world. If any member has an idea that might help - a legacy, a donation, sponsorship - then please contact us.

Finally, the IFSSH has a role in promoting and co-ordinating global partnerships around the world. The ExCo (in particular, the Members-at-Large) will be finding out who provides resources for education around the world and who might benefit from these resources. Our website has a new section in which we will post details of those member Societies with an outreach programme, as well as posting suitable teaching and assessment material. If anyone has information or ideas that would help our goal to support global partnerships, please let me know.

IFSSH Bylaws

The International Federation of Societies for Surgery of the Hand revised its bylaws in 2020 to address the preservation of institutional memory, to reduce the long time spent on Executive Committee when transitioning through multiple positions, to improve opportunities for societies to participate in the governance of the IFSSH, to improve the transparency of the Executive Committee nomination process, and to improve global representation on the Executive Committee. The 2020 bylaws have been successful in achieving these goals.

The 2020 Bylaws included provisions for an eventual move to a Biennial Congress schedule. However, during adoption of these bylaws, the Delegates' Council elected to preserve the Triennial Congress schedule.

This left the IFSSH in a position of having a triennial congress schedule but a biennial term duration for the Executive Committee positions.

In late 2022, the IFSSH Delegates were asked to consider bylaw changes that would be required to restore the Executive Committee terms to three years to be consistent with the Triennial Congress schedule. In addition to this, the proposed amendments to the 2022 bylaws contained a more detailed description of the Federation membership requirements and the management of ExCo vacancies, as well as reinstating the detailed description of the Federation membership requirements for further transparency (these were previously moved to the IFSSH Policies and Procedures).

It is a great pleasure to announce that the amended bylaws have been adopted by a significant majority, effective 15th November 2022. The Executive Committee wishes to thank the delegates for taking the time to vote on these amendments. The Executive committee would also like to thank our administrator, Belinda Smith for expertly managing a worldwide vote!

There were 67 eligible voters of which 60 voted (90%). Fifty-seven (57) approved the amendments, two (2) did not approve and one (1) abstained.

The Executive Committee sincerely appreciates the participation of the Delegates and the Societies that they represent. We believe these changes will significantly improve the governance of the Federation.

The current IFSSH Bylaws can be viewed on the IFSSH website: https://www.ifssh.info/pdf/bylaws-2022.pdf

IFSSH Communications

Under the leadership of IFSSH Communications Director, Prof Jin Bo Tang, the IFSSH website has been expanded to include a number of educational initiatives and detailed information on the IFSSH, its membership and its pursuits. Please take a moment to review the website (www.ifssh.info) and share the resources with your colleagues.

The IFSSH has engaged 10 enthusiastic hand surgeons as "social media correspondents" in late 2022. These correspondents are located around the globe and will be sourcing local and regional information relevant to hand surgery and the IFSSH and we will be sharing this news on our Twitter and Instagram accounts from early 2023. Dr Aida Garcia Gomez, the South American IFSSH Member-at-Large, will chair this group with oversight from Prof Tang. We look forward to the increased communication between the IFSSH and our membership, and to sharing this on social media as well as in our quarterly Ezine. Watch for our posts via @IFSSHand on Twitter and Instagram.

The IFSSH Ezine continues to be the mouthpiece of the IFSSH. Prof Ulrich Mennen produces this wonderful quarterly publication sharing hand surgery articles, member news, profiles of IFSSH Pioneers and items of interest to all. If your Society has news to share or your annual society scientific meeting to promote, please contact your society delegate (https://www.ifssh.info/member_nation.php) who can organise for this to be published. The Ezine is free of charge to all subscribers - simply sign up on the webpage (https://www.ifssh.info/ifssh_ezine.php) and it will be delivered direct to your email inbox in February, April, August and November.

Future Meetings

A detailed list of national and regional hand surgery meetings is available on the IFSSH website. The triennial IFSSH Congresses are as follows:

1st IFSSH Mid-Term Course in Hand Surgery
Guayaquil, Ecuador
31st January - 3rd February, 2024

XVIth IFSSH – XIIIth IFSHT Congress
Washington D.C., USA
23rd - 28th March, 2025

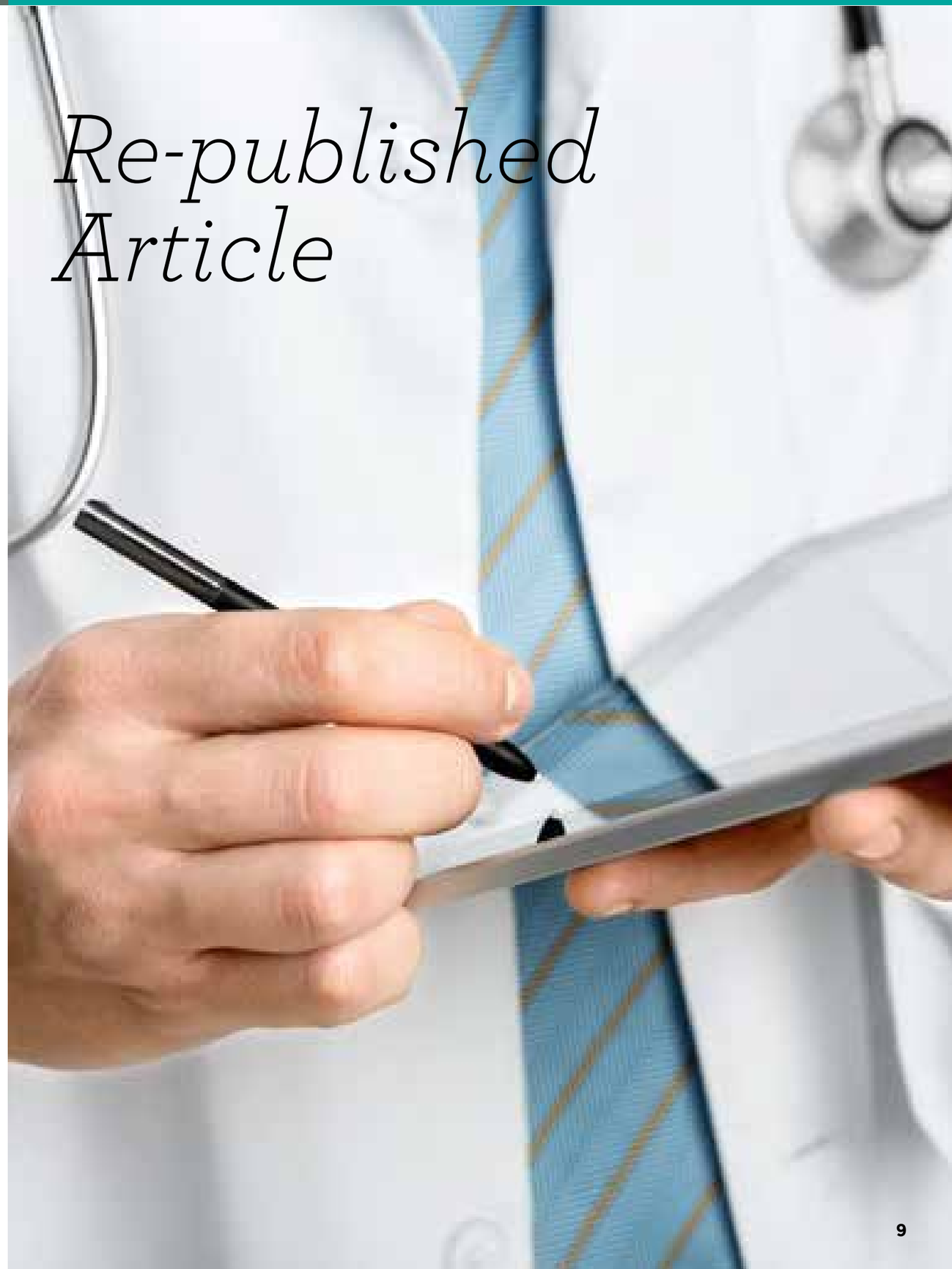
XVIIth IFSSH – IVth IFSHT Congress
Singapore
23rd – 27th October, 2028 (TBC)

Email: administration@ifssh.info
Web: www.ifssh.info
Twitter/Instagram: @IFSSHand

With very best wishes,
David

DAVID WARWICK
Secretary-General: IFSSH
davidwarwick@handsurgery.co.uk
+447887 651451

Re-published Article



EFFECTIVE THINGS SURGEONS CAN TELL PATIENTS DURING WIDE-AWAKE LOCAL ANESTHESIA NO TOURNIQUET SURGERY TO DECREASE COMPLICATIONS AND IMPROVE OUTCOMES

JHS (AM), VOLUME 4, ISSUE 6, P464-466, 1 NOVEMBER 2022

Donald H. Lalonde, MD

Like many hand surgeons, I learned the art and science of operating in the main operating room. Patients were there to have surgery, not for any kind of meaningful discussion. In fact, more than 90% of the conversations during surgery usually had nothing to do with the patient. Surgeons mostly shared stories with anaesthesiologists, nurses, and trainees about social issues and events of the day unless the conversation steered to surgical education.

In 1984, my first year of practice saw carpal tunnels and trigger fingers move to unsedated local anaesthesia. By the year 2001, more than 95% of my hand surgery had switched to wide-awake local anaesthesia no tourniquet surgery. With each passing year, the focus of intraoperative conversation moved away from talking to nurses about "the weather" to concentrating on the most important person in the operating room, the patient. Clearly, every operation has times of focus where less talking is better than chatter. However, times like skin suturing require less focus and are good opportunities for patient education.

Most unsedated, pain-free patients love the opportunity to speak to their surgeon during the surgery or while they are being injected with pain-free local anaesthesia. They want their surgery to be successful so they can solve their problem and resume their life as soon as possible. This is the best opportunity for patients to speak to us when we are both uninterrupted. I have learned over and over that effective things can be said to patients during surgery to decrease complications and improve outcomes in this time of their great thirst for knowledge from their surgeon.

Over the years, my intraoperative spoken words of advice have been carefully modified to improve their effectiveness. The purpose of this article is to relay some of the quoted intraoperative messages that I currently believe to be the most effective in the intraoperative education of patients during wide-awake local anaesthesia no tourniquet.

Communication Strategies

The indented quotes represent 37 years of refinement in the art of doctor-patient communication. All are direct quotes from the surgeon to the patient at the time of surgery.

Activities

"So … what WERE you planning to do this week?"

This intraoperative question is a good opening for a dialogue on successful behaviour after surgery. One of the main reasons for postoperative complications is that patients do things they should not be doing in the first weeks after surgery. This is especially true if the surgery is for a traumatic problem, such as a lacerated tendon or broken bone.

Undoubtedly, the patients had prior plans for the week after surgery. For example, playing hockey or building a house after a flexor tendon repair or a K-wired finger fracture is not going to produce a good outcome. The patient is most likely to listen to the surgeon during the surgery about recommended life-plan alterations. The patient is less likely to be open to good advice from their spouse or friends after the surgery.

"This hand only does 1 thing for the next 2–3 days until you are completely off all pain killers. It stays up higher than your heart whether you are walking around or sitting up at the kitchen table to eat with one hand. If you walk with it dangling down by your side, or if you use it to work, it will bleed inside the wound, swell more, hurt more, and take longer to get better. You are going to need to be a one-handed woman for the next 2–3 days. Do you have any help at home?"

Patients respect their surgeon. If a surgeon tells their patient not to walk around with their hand dangling down, they will be less likely to do that. If we tell them this will increase swelling and bleeding in the wound, which hampers recovery, they will understand it better. I tell them it will also increase the chances of infection, especially if the patient has transcutaneous skin sutures[1].

If those words are spoken to patients by the surgeon during awake-surgery, most are likely to listen and remember much more than if they are sedated or if they get the same information in a pamphlet that they cannot or may not read. If they get the information verbally from a nurse after sedation, they are less likely to remember it because of the amnestic effects of sedatives.

Pain management strategies

"What would you normally take for pain if you have something like a headache? Advil? Tylenol?"

If the patient tells me they normally take an over-the-counter, benign pain medication, I tell them:

"That is all you are going to need after this operation if you follow the simple rules of keeping your hand higher than your heart and keeping it quiet until you are off all pain killers[2,3,4,5,6].

Treat it like a sleeping baby; don't disturb it! You can take a little Advil and/or Tylenol after the freezing (numbing medicine) wears off this evening and maybe again tomorrow if you need it. However, if you keep your hand quiet and higher than your heart, the sting of the cut (break) will be gone by 2–3 days from now and you will get into the pain of 'gee, doctor, now it only hurts when I put my hand down or when I try to use it.'

When that happens, you stop taking all pain medicine and listen to your body. We did not spend 2 billion years evolving pain because it is bad for us! It is your body's only way of saying: 'Mary, would you please stop that? I am trying to heal in here and you are screwing it up!!!' That is a little voice in your head you should listen to, and you cannot hear it with Advil or Tylenol in your ears. That is why you quit taking pain medicine after a couple of days and follow 'pain-guided healing.' Just don't do things that hurt! It's also called common sense!!! Don't put your hand down or try to use it until it doesn't hurt anymore to do those things."

Clearly, the advice will be different for the patients who are on chronic pain medication, because they don't know what hurts. I advise those patients to immobilize and elevate longer and decide on a case-by-case basis how to handle them.

Wound hygiene

If I have only done a soft tissue operation that does not need a splint, such as carpal tunnel, trigger finger, lacertus release, or Dupuytren's fasciectomy, I tell them:

"You can take off the bandage and get in the shower tomorrow or the next day with a naked hand. It's a myth that you can't water fresh wounds[7]".

You don't need to rub it with soap, but it's OK if a little soap or shampoo run over it. You are still not using the hand in the shower because you are still keeping it higher than your heart until you are off all pain killers, and you know what hurts! After your shower, you can rewrap your hand with a clean bandage that does not need to be sterile[8]".

I explain to patients about the bandage (usually just a rolled, clean, gauze bandage with a clean, gauze pad underneath).

"This bandage does not stop bleeding and does not stop infection. YOU stop bleeding and YOU stop infection by keeping your hand up higher than your heart and keeping it quiet. However, you are normal, and you are human, so you are going to forget to do that. When you forget and go to put your hand down or to use it, you will see the bandage and it will remind you to keep your hand elevated and quiet. You can wear it for 4–5 days until you and those around you are used to the idea that you are following pain-guided healing[9]".

Flexor tendon intraoperative advice

During a flexor tendon repair, the following advice can be very helpful (see the Video: https://www.jhsgo.org/article/S2589-5141(22)00055-X/fulltext#appsec1)

"It is most important that this hand stays up and quiet until I see you here with my hand therapist in 4 days. That gives time for the internal bleeding to stop, the swelling to come down, and lets you get off all pain killers so we can start pain-guided movement of up to half a fist the next time I see you. Your hand will be like a report card.

If it is swollen like a football, I will know you have been walking around with your hand dangling down by your side. If it comes in looking pretty much like the other hand, I will know you have been keeping it up higher than your heart and quiet for the last 4 days. You saw your hand make a full fist and straighten out all the way today, so you know it will not come apart if you only do up to half a fist of flexion with the therapist. If you move your tendon too much or if you jerk it or use it, the repair will rip apart because a normal tendon is much stronger than a sutured tendon[10].

If you don't move it enough starting in 4 days, it will get stuck in scar. If you rip this tendon repair apart, the chances of us getting a good result is much smaller. If you get stuck in scar, you may need another operation called a tenolysis. You just want to keep your tendon gliding a little, so it does not get stuck.

That is why it is so important that you attend all your visits with the hand therapist so she can help you decided what is too much and what is not enough safe movement. If you do everything your therapist and I ask you to do, the chances are good that you can get a good result[11,12]".

Summary

It is difficult to measure and quantify the outcome improvement effect that arises from good-quality, uninterrupted intraoperative conversation between a patient and their surgeon during surgery.

However, this surgeon is convinced that this is one of the main improvements in his career, which has led to better results and fewer complications.

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HAND SURGERY:
Should it be a separate specialty?

WEE LEON LAM AND DANIEL HERREN

INTRODUCTION

At the recent International Federation of Societies for Surgery of the Hand (IFSSH) Congress in London, there was a most interesting session on training in hand surgery led by Matthew Brown, Brigitte van der Heijden and Daniel Herren. Much of the debate focused around whether hand surgery should be a separate specialty or remain part of a parent speciality like orthopaedics or plastic surgery. The subject is an important one. Debates about the pros and cons of each training pathway has continued for decades. To coincide with the global theme of IFSSH and to highlight its importance, the Journal of Hand Surgery (European Volume) invited a few countries to share their perspectives about Hand Surgery training in the June 2022 issue (see bibliography). In particular, they were asked to describe their particular training pathway and at the same time, to highlight its pros and cons. This article summarizes some of their views as well as provides further perspectives about the future of hand surgery training.

There exist gross inequalities in healthcare services around the world. We must emphasise that these views are those of a select group of 4 countries where there is highly adequate resource for training and provision of care in plastic, orthopaedic and hand surgery. However, it is hoped that the discussions will provide a framework for hand surgery training in any country, regardless of the resources.

HISTORICAL PERSPECITVES

In terms of specialties, hand surgery is considered relatively young even though for centuries, surgeons have contemplated the complexity and importance of this incredible organ. Due to its small size, the hand was easily regarded as just another limb appendage and therefore logically considered a small subspecialty of orthopaedic surgery. It was not until the 1940s that the significance of the hand was fully recognised. Tragically, it took two world wars for surgeons to realise how mutilating hand injuries can profoundly affect a person's life.

In the past, surgical specialties have perhaps focused on getting hand wounds healed, and when a hand is severely injured, to amputate it much like the way lower limb injuries were treated. These early surgeries did little to restore hand function to a point where return to work or daily activities was possible.

Following the Second War World, especially through the efforts of Sterling Bunnell in the USA, there was increased realisation of the importance of the hand with clearly defined surgical techniques and optimising outcomes. The seed was planted for hand surgery to become a separate subspecialty. After all, if an organ is so important why not devote more time, resources, and training towards optimising its surgical outcomes?

Countries where hand surgery is a separate specialty.

This was perhaps the consideration for countries like Finland, Sweden, Singapore and Switzerland where hand surgery did become a separate subspecialty. Following a short period of general training in other larger specialties like plastic, orthopaedic or general surgery, hand surgery residents in these countries would undergo a period of specialised training only in hand and upper limb surgery for at least three years.

In Sweden, the entire specialist programme is a minimum of five years. In Finland and Singapore, this is around six years. The specialist training is usually held in University hospitals where complex cases are concentrated so that residents can be exposed to the wider range of tertiary procedures including microsurgery, congenital hand surgery, complex nerve surgery and tetraplegia reconstruction. All residents were assessed during their training pathway according to national guidelines. Summative assessments, in the form of a final examination, are not compulsory in all of these countries although residents regularly undergo competency-based assessments and receive mentoring and training under the supervision of experienced hand surgeons.

Countries where Hand Surgery is not a separate specialty.

To provide views from countries where hand surgery is not a separate specialty, we invited two articles from the United Kingdom (UK) and United States (USA). In these countries, hand surgery continues to be part of a parent specialty like orthopaedic, plastic or less commonly, general surgery.

In the UK, aspiring hand surgeons complete a 2-year foundation programme in order to be fully registered as a doctor, followed by a 2-year core surgical rotation before finally applying for a 6-year specialty training in either orthopaedic or plastic surgery, where hand surgery is part of the curriculum. Finally, aspiring hand surgeons would usually undertake a dedicated hand fellowship.

The training pathway is similar in the USA, minus the foundation year programme and core surgical training: general, orthopaedic or plastic residents will start their residency straight after medical school followed by a 1-year hand fellowship. It is worth noting that premedical studies are necessary in the USA before starting medical school, and therefore the overall training period is probably similar to the UK.

DIFFERENCES BETWEEN THESE TWO SYSTEMS

The main differences between a system where hand surgery is a separate specialty versus one where it is not, are the length as well as the scope of training. In the former, hand surgery training starts much earlier and focused on the hand for longer. Residents do not have to develop competence in breast reconstruction (unlike plastic surgery residents) or hip arthroplasties (unlike orthopaedic residents) or bowel anastomosis (unlike general surgery residents).

The assessments of competence in these systems are understandably different and would probably be more detailed and comprehensive. Finally, an additional hand fellowship in these countries appears to be optional, except perhaps in Singapore.

In the UK and USA, hand fellowships are almost compulsory and national hand fellowships within the UK and USA have been developed and refined over decades to a very high level. This is necessary as the aim of these fellowships is to try and cover the entire range of hand surgery within a very short time.

However, whether this is achievable or not remains debatable. In the USA, finishing a 1-year hand surgery programme may not produce competency in all areas. The author argued the need for at least a 2-year fellowship to fully train a hand surgeon who can be equally competent in fixing a distal radial fracture or raising a free flap but admitted there are considerable challenges to implement this because of the already long training in the core specialties. In the UK, it seems acceptable that a 1-year fellowship would provide excellent competence only in certain areas and limited exposure in others, but that any deficiencies will be compensated by other hand surgeons working together in ortho-plastic hand units.

WHICH IS BETTER?

Table 1 summarises some of the pros and cons of either system. The list is not comprehensive, and we expect (and welcome) readers of this article to suggest more points for discussion. As mentioned, proponents of a separate pathway argues that aspiring hand surgeons can focus on the relevant training earlier and longer, which may make them 'better' hand surgeons in the future.

In Finland, the authors also viewed that more non-hand cases can be reserved for orthopaedic and plastic surgery residents as these do not need to be shared with those who eventually wish to specialise only in hand surgery. Autonomy over the specialty also seems advantageous; a hand specialty committee can choose who they want to train and also the number of hand surgeons in line with national requirements. All three countries, especially Singapore, argued that a patient will benefit from a certified hand surgeon rather than a general orthopaedic or plastic surgeon.

Table 1: Pros and cons of hand surgery as a separate specialty

Hand surgery as a separate specialty - Pros	Hand surgery as a separate specialty - Cons
Shorter and more focused training period	Less and shorter period of exposure to the wider field of surgery in relevant areas, e.g., microsurgery, flaps, shoulder and elbow surgery
More opportunities to cover the entire range of hand surgery within the training period	Difficulties in balancing the number of trained specialists versus more generalists
More focused assessments based on hand surgery	Difficulties in perhaps covering certain rural areas where patients have to travel significant distances for minor procedures.
More autonomy over recruitment of future hand surgeons	
Treatment likely in more specialised centres by hand specialists rather than by generalist with hand surgery interests	

Hand surgery as part of a parent specialty - Pros	Hand surgery as part of a parent specialty - Cons
Allow broader exposure to other specialities which would allow wider management especially of the trauma patient	Protracted training pathway with long periods spent in 'irrelevant' areas
Allow better cross-fertilisation of ideas, with possible increased innovation	Dilute the overall experience for orthopaedic or plastic trainees as these are shared among all trainees within the training period
Allow trainees the time and space to choose their desired specialty after a wider exposure	A 1-year hand fellowship after completion of parent speciality training may not allow the development of full competence in all areas of hand surgery
Result in better trained generalists within every hospital who can perform common hand surgeries outside University departments, usually concentrated in major cities	Level of care provided may not be as high as compared to those within University departments
More job opportunities in smaller hospitals since most hand surgery departments are part of another speciality	

Finally, dedicated hand centres may allow the formation of dedicated rehabilitation units facilitating close collaboration with hand therapists.

What about the cons of a separate specialty? Mainly these revolved around the lack of cross-pollination or cross-fertilisation of ideas from other specialties. The Swedish authors honestly admitted, for example, a hand surgery resident would have less experience in microsurgery as compared with a plastic surgeon, and also less experience with shoulder and elbow surgery as compared to an orthopaedic surgeon.

This view is also supported with observations in Switzerland where hand surgery has been a unique specialty since 2015. Also, although the idea of a more specific educational program that starts earlier may seem attractive, it does not necessarily always guarantee a higher level of skills at the end of the overall educational period. It is important that basic principles of surgery and patient care remain an integral part of hand surgery teaching and the more complex procedures should probably be reserved for senior residents and hand fellows.

Proponents of hand surgery as part of a parent specialty, especially from the UK, argued that plastic or orthopaedic trainees bring along with them unique skillsets and perspectives which may prove invaluable when managing a postoperative complication or

trauma outside the upper limb. The wider implication is that societal needs can also be better addressed; if hand surgery becomes a unique specialty in the UK, argued the authors, then hand surgeons can only work in certain cities resulting in patients having to travel significant distances from rural areas for treatment. Furthermore, these would lead to significant gaps in the general plastic or orthopaedic on-call rotas.

THE FUTURE OF HAND SURGERY TRAINING

The search for the perfect training pathway may not ultimately result in a 'one-size-fits-all' solution. For those countries where hand surgery is a unique specialty, favourable circumstances may have existed at the time to allow its 'successful' separation from other larger specialties. However, this may not necessarily mean that such separation is always the best solution and that other countries should do the same thing if circumstances allowed.

Manpower needs and resources are a major consideration and in certain countries, it is simply not possible to employ surgeons who only do hand surgery due to on-call or workload burdens. In countries with larger populations and geographical constraints, it may be impractical for all hand patients to travel to one centre which would have to cater for a very wide catchment area.

It would appear that the current solution, whether this be in countries where hand surgery is a unique specialty or not, is to find some kind of balance. Even in the former, trainees would spend time in a larger specialty (orthopaedic or plastic surgery or in the case of Sweden, anaesthesiology) before embarking fully on a training in hand surgery. Singapore has a well-defined 2-year Surgery-in-General (SIG) programme that provides a broader overview of surgery and also facilitates professional networking.

For either system, perhaps a 'hub-and-spoke' arrangement would work well: rarer and complex upper limb surgeries are concentrated in only a few University centres whereas simpler and common procedures can be shared among plastic or orthopaedic colleagues.

Each country would need to find what works best, not just from the patient's perspective but also the wider societal and national health service resource perspectives. Finally, it is worth noting the benefits of international hand surgery examinations that are open to candidates from different countries, regardless of the system. This is the aim of the European Board of Hand Surgery (EBHS) examination, an initiative started by the Federation of European Societies for Surgery of the Hand (FESSH).

Applicants for the EBHS examination are required to submit a logbook proving they have met the minimum requirements. If eligible, they have to undergo a robust assessment of their knowledge (theoretical and practical) by seasoned hand surgeons from all over Europe. In this way, a certain level of standard can be maintained to ensure hand surgery is practised more safely among our patients.

As mentioned in the beginning, there exist healthcare inequalities in various countries where such training infrastructures, as described above, is not yet possible. However, it is hoped that this article has touched upon certain points for considerations when implementing a Hand Surgery training programme.

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(please visit the Journal of Hand Surgery European website to read these articles, which will be freely available for a limited period of time)

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6. Chung K. Hand surgery training in the United States of America. J Hand Surg Eur. 2022, Vol. 47(6) 675–676

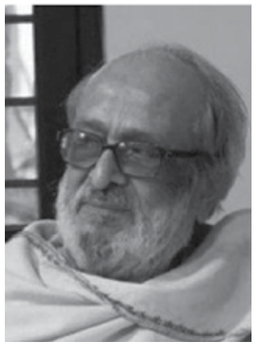
This topic has also been discussed in a number of previous publications. For an example, an international perspective is given in the paper:

Tonkin M, Shewring D, Chang J and Tan D Future and trends in hand surgery training worldwide. J Hand Surg Eur. 2018, 43: 787-792.

WEE LEON LAM
Consultant Plastic and Hand Surgeon
Royal Hospital for Children and Young People, Edinburgh St John's Hospital, Livingston
Honorary Clinical Senior Lecturer, University of Edinburgh
Editor-in-Chief, Journal of Hand Surgery (European)
lamweeleon@googlemail.com

DANIEL HERREN
Head of Hand Surgery
Schulthess Klink
Lengghalde 2
8008 Zurich / Switzerland
+41443857481
Daniel.Herren@kws.ch

Hariharan Srinivasan (1929-2015)



Srinivasan was born on 7 September 1929 in Madras, India, and had his schooling in Vellore, Arni and Tambaram. He completed his medical degree (MBBS) in 1952 at the Madras Medical College in Chennai. He got his FRCS(Edinburgh) in 1957 and FRCS(England) in 1958 while working from 1954 to 1958 in hospitals in Birmingham, North Wales and London. In 1959 Srinivasan returned to India and worked in the Government Wenlock Hospital and Kasturba Medical College in Mangalore, Karnataka.

In 1962 he became a full-time orthopaedic surgeon at the Central Leprosy Teaching and Research Institute (CLTRI) in Chengalpattu until 1984, when he became a research consultant at the Portland Hand Surgery and Rehabilitation Centre in Portland, USA.

Srinivasan is one of the pioneers of surgery in leprosy-affected patients, and developed innovative techniques in reconstructive hand surgery. He became a member of the WHO Expert Advisory Panel for Leprosy in 1985 and published an important monogram for them on surgical corrections of the deformed hand, which was distributed world-wide. He joined the JALMA Institute for Leprosy in Agra, India in 1987 to 1990. In 1990 to 2001 he was Editor of the Indian Journal of Leprosy (which later became 'Leprosy'). He published over 90 medical articles, three books and contributed 10 chapters for textbooks. He lectured widely and was a popular teacher in India and abroad. He retired form clinical work in 2008.

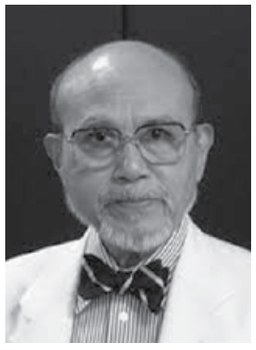
Dr. Hariharan Srinivasan received numerous awards for his many contributions, which include the Chinnaswamy Pilai Prize, the Bradfield Memorial Prize, Best Junior Speaker Medal, the JALMA Trust Fund Oration Award (1979), the International Gandhi Award (2004) and the Padma Shri decoration by the President of India in 1984. He received the Doctor of Science (Honoris Causa) from the Medical University of Tamil Nadu in India in 2004.

He was President of the Indian Society for Surgery of the Hand and President of the Indian Association of Leprologists.

Hariharan was a prolific writer in Tamil, using five pseudonyms amongst others 'Charvakan'. His stories and novelettes are about the philosophy of life. He was a contributing editor of the 1328 page Tamil-English dictionary. He passed away on 21 December 2015 in Chennai, India.

Hariharan Srinivasan was honoured as "Pioneer of Hand Surgery" in March 2007 at the Tenth Congress of the IFSSH in Sydney, Australia.

Susumu Tamai (1935)



Susumu Tamai was born on 13 March 1935 in 1017 Toichi-cho, Kashihara-City in Nara, Japan. He was the 21st uninterrupted generation of doctors in his family which spans a continuous period of more than 355 years. He graduated from the Medical University of Nara in March 1959, and completed his Orthopaedic training at the same University. In April 1964 he gained his PhD with the thesis "Experimental Surgery on Replantation of Amputated Limbs in Dogs".

Tamai continued working in the Orthopaedic Department and became Associate Professor in 1982, and in 1989 Professor and Chairman of the Department until his retirement in March 2000.

He concentrated on hand surgery, and was interested in the causes and management of the avascular necrosis of the scaphoid bone. However, microsurgery was his main focus, and he is credited with the first successful replantation of a completely amputated thumb in a 28 year old man on 27 July 1965. This achievement heralded a new dimension in the field of Hand Surgery. He was also the first to perform a successful big-toe-to-thumb transplantation in Japan (1973). After his retirement as Head of the Orthopaedic Department, he established and was the Director of the Nara Microsurgery/Hand Surgery Institute at the West Nara Central Hospital where he continued to operate until 2006.

He was also President of the Nursing School at the Nara Medical University (1994-1996), President of the Nara Prefectural Rehabilitation Centre for the Mentally and Physically Handicapped (1999-2000) and President of the Heisei Rehabilitation College in Nishinomiya (2006), and President of a number of professional medical Societies.

Prof. Tamai published a vast number of books, chapters and articles, many in English. He was invited as guest lecturer and visiting professor numerous times internationally, which included the Founder's Lecturer at the 36th Annual Meeting of the American Society for Surgery of the Hand (February 1981), Visiting Professor to the Kleinert, Kutz and Associates Hand Centre in Louisville , Kentucky, USA (August 1996) and International Guest Lecturer at the 55th Annual Meeting of the American Society for Surgery of the Hand (October 2000). In April 2000 he received the Academic Achievement Award of the Japanese Orthopaedic Association.

Susumu is married to Aiko and they have two daughters and a son. He loves photography, art and cooking.

At the Tenth Congress of the International Federation of Societies for Surgery of the Hand in Sydney, Australia on 11 March 2007, Susumu Tamai was honoured as "Pioneer of Hand Surgery"

How is my patient doing?

SUPPORTING PATIENT-CENTERED CARE WITH THE USE OF AN OUTCOMES DASHBOARD

Increasingly clinicians collect patient-reported questionnaires and clinician-reported measures to ensure patient-centered care. However, it is difficult to visualize all this data to support clinicians in their daily consultations.[1-3]

We follow the International Consortium Health Outcome Measures (ICHOM) tracks for patients with hand and wrist problems.[4] This includes patient-reported outcome measures such as the Michigan Hand Outcome Questionnaire (MHQ) or Patient Specific Functional Scale (PSFS) and measurements taken by therapists such as strength or range of motion. Clinicians assign these tracks in the electronic patient record through which online questionnaires are sent to patients. We designed a dashboard for hand therapists and surgeons to provide meaningful data in a simple and compact overview. Color coding (red -orange- green) highlights values that deviate from the expected value based on patient data. This highlights if there is little room for improvement or if there are risk factors that imply potential poor recovery. This dashboard is integrated with our electronic patient record system and consists of three different sections.

What matters to the patient?

The first section displays the patient-reported request for help, their personal goals, pain and function scores, and the results from a screening instrument for psychological profile, such as patient concerns and catastrophizing. With this information, hand therapists can tailor care to individual needs, such as the patient's goal of returning to sports (Figure 1).

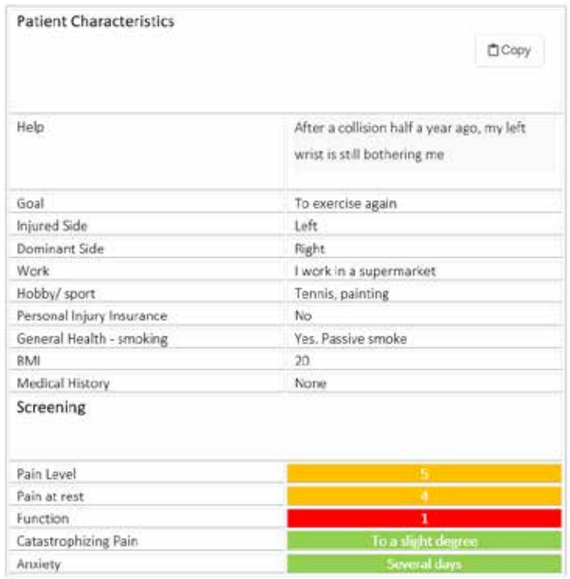


Figure 1. Patient characteristics with information about the patient-reported request for help, their personal goal, hobbies/sport, and medical history. The second part shows results from a screening instrument for psychological profile.

This makes the conversation more focused and personalized. Clinicians can also manage the expectations of patients in case the patient wants to achieve something that may not be attainable. When the pain score is very high, the therapist can ask the patient about the influence of the pain on daily life. Or, if the patient is very worried, the conversation can be started by saying: 'I see that you are very concerned. Can you tell me more about this?'

How is the patient doing?

The second section shows patient-reported and clinician-reported outcome measures to evaluate the patient's progress over time. For example, suppose strength is still reduced compared to preoperatively (Figure 2), then the therapist can discuss the outcome with the patient and adjust the therapy, focusing more on strength training. Patients' results are also plotted against the results of all previous patients for reference, helping therapists put the recovery phase in a broader perspective. Patients often ask: 'I still have much pain, is that normal'? This normative information can motivate or reassure patients about their treatment progress.

Figure 2. Patient-reported outcome measures to evaluate the patient's progress over time. Data presented on admission and at three months. The goal for hand therapy is displayed; in this example, the patient's goal is to return to her sport (tennis). Progress over time is measured at admission (intake), three months and (depending from the measurement track) twelve months.

What outcomes can be expected?

The third section of the dashboard shows predicted outcomes for the individual patient. Based on our extensive outcomes database, we have developed prediction models that allow us to calculate the probability that a clinically meaningful improvement is reached. For important outcomes such as pain, return to work, and hand function, these probabilities are adjusted based on patient-specific characteristics such as age, gender, pain on admission, the severity of illness, and comorbidity[5]. These individual predictions can help manage expectations and may be used during shared decision-making to ensure the most appropriate treatment. The example illustrated in Figure 3 shows this patient's chance of a relevant pain reduction at rest is estimated at 69%.

Future plans

We are currently assessing how the dashboard is used in practice and its effect on everyday service delivery, both from the clinician and patient perspectives. In particular, we are studying how clinicians use the dashboard, whether it supports discussing expectations, aids decision-making and goal setting, and facilitates treatment evaluation.

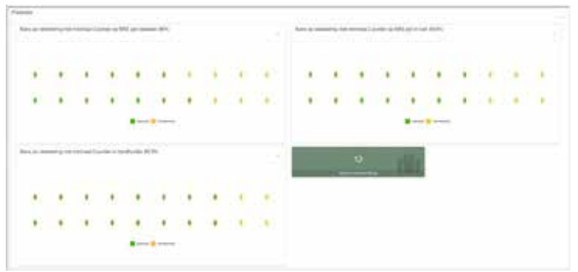


Figure 3. Personalized prediction models for expected pain, functionality, and return to work. In the example, you see that the return to work for this patient is estimated at twelve weeks. The green figures show the probability of someone improving at least 2 points on the NRS score for pain. The yellow ones indicate the probability that there will be no such improvement.

And from the patient side, what do they think about seeing outcomes presented in the dashboard and whether the information helps them in decision-making.

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YARA VAN KOOIJ is a hand (physio) therapist at Xpert Handtherapie in the Netherlands and PhD researcher at Erasmus MC Rotterdam (Department of Rehabilitation Medicine and Plastic, Reconstructive, and Hand Surgery).

The dashboard development was a team effort from hand surgeons, hand therapists, patients, IT specialists, and researchers from Xpert Clinics, Xpert Handtherapie and Erasmus MC.

ifsht International Federation of Societies for Hand Therapy www.ifsht.org

IFSHT NEWSLETTER – REACH VOLUME 2, NO. 3 IFSHT February 2023

The IFSHT is excited to present the third issue of the second volume of the IFSHT newsletter which is available here:
https://ifsht.org/publications/?publications_category=29

The publication aims to collate Research, Education, Achievement and Clinicians in Hand and upper limb therapy around the world.

This edition of REACH contains our last segment in the Levels of Evidence section, research highlights and clinical pearls. The Spotlight On! Section features the Swiss Society of Hand Rehabilitation and we also introduce our new "Volunteer" section, showcasing fabulous work by therapists and surgeons in the Ukraine. The issue also features some of the recipients of the prestigious Lifetime Achievement Awards at the Triennial Congress including Jennifer (Jenny) Ball and Sandra Artzberger.

We call on hand and upper limb therapy clinicians and researchers to submit any contributions for consideration to: informationofficer@ifsht.org.

UPCOMING EVENTS

The FESSH-EFSHT 2023 Congress is being held from 10th -13th May 2023 in Rimini, Italy. Please follow the link for more details: https://fessh-efsht2023.com/

Other Recent National & International Events & Congresses

On 23rd February, the South African Society of Hand Therapists (SASHT) and The University of the Witwatersrand Occupational Therapy Department are holding a Consensus Development Conference (CDC) that will contribute towards strengthening hand-injury care services in the South African Public Sector. Please follow the below link for details: https://www.quicket.co.za/events/199694-consensus-development-conference

ON PUBLICATION:

The author, The reviewer and The editor

At times, the relationships among authors, reviewers and editors may be a little fraught despite a common aim, that being to publish good quality articles. Much of the advice in our literature and that from oral presentations concentrate on directions from editor to author. After 30 years' experience in all three roles, I beg the readers' indulgence in making the following observations and offering some advice to all three groups.

The author:

In the main, information contained in the submission should be novel or perhaps supportive of another publication on a topic about which controversy exists. In my opinion, the latter is appropriate for publication, despite the information already appearing in the published literature.

Each journal has its own character and its own rules. Although some of the latter are formulaic and apparently restrictive, it is wise to closely read the instructions to authors and comply in as best possible a manner. Failure to do so will result in the return of your manuscript by the "gate-keeper", without reviewer or editor consideration of its worth, particularly if it contains too many words or if references are listed incorrectly. A covering letter of explanation may be of benefit if you believe that your submission should receive some allowance beyond the scope of the "rules".

Most journals demand a format based on an Abstract (Summary) followed by an Introduction, Methods and Materials, Results and Discussion.

Each author should ask himself "What is the aim of my submission?"; "Do the methods and materials allow the aim to be realised?"; "What are the results and are they meaningful?"; and "Do the results allow valid conclusions and do these satisfy the aim of the article?"

The determination by some journals to demand the use of the first person and an active tense is, in my mind, questionable. The late Adrian Flatt, a marvellous man and a past Editor of the American Journal of Hand Surgery, was one of the proponents of accepting responsibility: "I cut the median nerve" rather than "The median nerve was cut". I believe that this concept, although worthy, may be taken a little too far. It is irritating for the reader to be constantly bombarded with the words "I" and "we"; it is often inaccurate in that "I" may not have "cut the nerve" and "we" may not have been there at the time. Placing one's name to the article denotes acceptance of responsibility for its content. I believe that most medical writing should be in the passive voice. However, in the Discussion, where preference or belief of the author is stated, "I" and "we" are appropriate.

There is little place for adjectives or adverbs in medical writing. These should be kept to a minimum but may qualify opinions.
Adrian Flatt also advised placing your "perfect" manuscript in a drawer for a time, for me minimally a week, then re-reading it. This is sage advice. Flaws may become obvious.

Try to read the manuscript as a reviewer would. Perhaps the greatest error is to overstate the conclusions if the data provided is less than supportive. You should avoid conclusions which have not been addressed in the Methods or Results. Ask a colleague, not a co-worker or one who is beholden to you, to review your article prior to submission.

One final piece of advice is to refrain from feeling insulted when your manuscript is "improved" or rejected by reviewer and/or editor. Consider the points made and respond objectively – again after at least one week's delay. In doing so, avoid sycophantic praise of the reviewer/editor as diligently as you avoid resentful criticism.

The reviewer:

Editors rely on the goodwill of reviewers, whose role is invariably unpaid and little recognised, except for the dubious honour of acknowledgement in a list placed at the rear of a journal from time to time. The invitation to provide a review is a reflection of that person's standing.

Appropriate acknowledgement and appreciation from an editor is helpful. Nevertheless, the reviewer, whilst highly regarded, is not a protected species and may do well to consider the words that follow.
Your approach as a reviewer should be to consider the same questions which the author is advised to ask of himself (as detailed above in paragraph 3 in the author section).

> "... a journal is for the benefit of readers and authors; editors and reviewers are but the vehicles...."

It is not your work that you are reviewing, so try to place yourself in the position of the author. Read the whole manuscript before editing line by line or word by word, so as to understand the gist of the content and to determine its worth. Is it new or hackneyed information? Is it of interest to the reader? Misuse of a word, individual preferences for differences in style of expression, quality of figures, and the like are secondary matters which may be listed for the authors' consideration after an analysis of the article as a whole.

"Validated, objective scales of assessment" may be invalid and/or irrelevant. Question these. Ask yourself whether statistical significance is clinically relevant. Seek advice from statisticians when you need it.

A review is not a forum for one's own personal preferences–write your own article. Avoid adjectives and adverbs as they too often display a perjorative sense of disagreement, displeasure or a foul mood (temporary or permanent).

Consider whether the judgement and demands you make of the author are realistic rather than assuming a position of "divine right", often bestowed by one's self at a time removed from active participation in and responsibility for the outcome of the work one is judging. If you refer to another's work to make a point, make certain the reference is valid and not a misinterpretation from your own memory.

If your criticism is factually incorrect, accept graciously that you may be criticised in return. Don't send your review immediately but rest it for a time. When able to consider the opinions of other reviewers, avail yourself of the opportunity. It may help you.

Personal abuse and sarcasm are to be frowned upon. Even light humour may be misinterpreted – take care.

The editor:

This is an influential, prestigious and powerful position - encouraging submissions, inducing colleagues to review these submissions, maintaining quantity and quality of production and smoothing ruffled feathers (pride) when a submission is not accepted for publication.

It is my observation that you may occasionally shirk the responsibility of informing a reviewer that the review to be forwarded to the author is perhaps a little harsh. You should take the responsibility of reviewing the reviewers' comments, having read the article yourself.

This demands an active role early in the editing process, preferably forming an opinion before reading those of the reviewers. Particularly, in the not uncommon circumstances when reviewers provide conflicting advice, you should gently intervene as such conflict confuses the author. I believe that the role of intermediary between reviewers, and between reviewers and authors, is a primary responsibility of the editor.

If an author raises concerns about the validity of a reviewer's comments, the editor should not automatically assume that the author is wrong and that the position of reviewer demands protection. A delay between receipt and response may be as advisable as that recommended for author and reviewer.

A gentle touch is helpful. After all, you are supporting both author and reviewer.

The editor may determine that any particular submission will never be suitable for publication. If so, the author should not be directed to resubmit following attention to specific comments. Polite rejection is appropriate after the initial review.

Attention to most concerns should be addressed by editor and reviewers at the time of the first review, if at that time the content of the manuscript is considered to be publishable. If the authors can respond adequately to these concerns, remaining editing should be minimal. I believe that this approach is preferable to multiple edits, although some circumstances will demand the latter approach.

Finally, a word on "Instructions to Authors". These are too complex and often contradictory. Some flexibility in application of rigid instructions may create a more interesting tome.

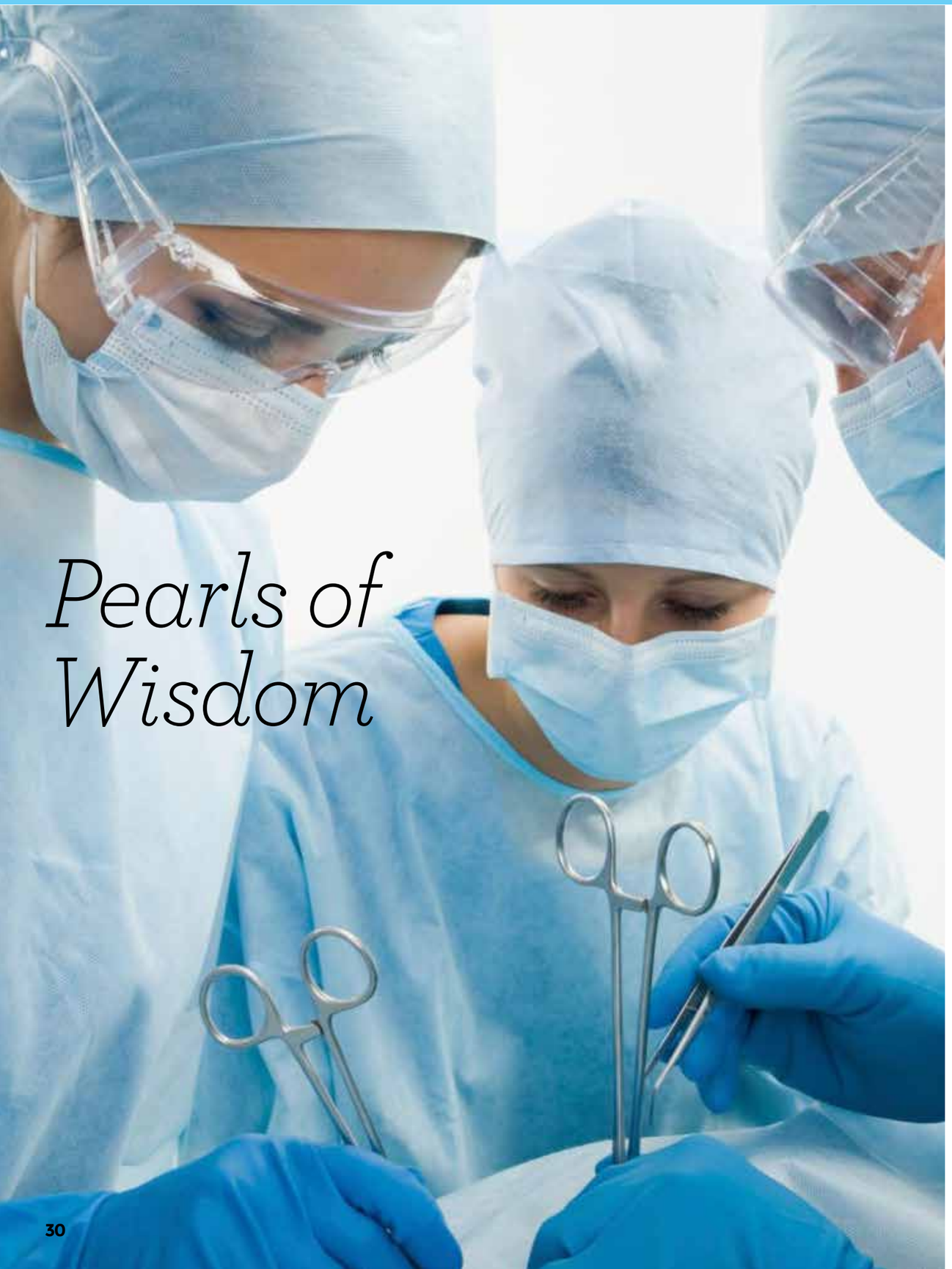
In conclusion, a journal is for the benefit of readers and authors. Editors and reviewers are but the vehicles by which this is achieved. However, we should remind ourselves that most reviewers and editors are authors. Their interests coincide.

It has not been my intention to offend. However, if I have offended one, whether author, reviewer or editor, far better to have offended all equally.

MICHAEL TONKIN
Aspirational author,
unappreciated reviewer and hopefully,
understanding editor.

Acknowledgment:
Permission is given to re-publish this article (with some changes)
which originally appeared in "Hand Surgery" 2013, 18(3), 1-2

PEARLS OF WISDOM



Pearls of Wisdom

Challenging Current Wisdom in Hand Surgery

Editorial

Evidence-Based, Eminence-Based, Hypothesis-Based, or Wrong Information–Based Practice?

Healthcare givers—including those in hand surgery—are commonly considered to deliver their clinical treatment to patients based on evidence, eminence, or a combination of both, in order to obtain the best possible diagnoses and treatments. Therefore, correct clinical practice is often described as evidence- or eminence-based practice. I consider that two other categories of clinical practice exist but have not drawn sufficient attention. They are *hypothesis-based practice* and *wrong information–based practice*.

Hypothesis-based practice, using surgery as an example, is seen in two situations. The first is when treating rare and relatively uncommon disorders. The caregivers have no evidence or no reliable evidence to base treatment, even in consultation with senior colleagues, who also have neither evidence nor experience to support the practice they will give. They have to decide a treatment based on rationales or guesses and hypothesize that their treatment is the best according to the doctor's understanding, knowledge, and reasoning. The expertise level of even senior caregivers on these particular clinical problems can only be level II according to classification of Tang and Giddins.[1] There are no experts or experienced specialists. The second situation is when the treatment method is new and therefore experimental without evidence or eminence to support.

Wrong information–based practice exists more commonly than we recognize. The caregivers decide to use a clinical treatment based on published clinical data or conclusions, which are wrong in reality. The most detrimental are published false or largely unreliable clinical data and outcomes. Caregivers have no way to know that the information is false. These false reports are ideally caught before publication or retracted after the problems are exposed. In reality, detection of such problems is difficult, and sometimes even with solid facts of major misconducts of the authors, some journals do not act to retract or correct the published papers. This problem is worsened by emergence of a large number of journals of low quality or predatory in nature, which publish articles after loose peer-review and lenient editorial processes. Some of these journals are included in search engines, which makes suspicious data weigh similarly with those published in authoritative or serious journals. This is an emerging serious issue in the recent decade with expansion of literature, because not many colleagues look into or realize stringency of different journals.

Systematic reviews are often subject to journal stringency. The criteria for inclusion or exclusion of articles under systematic review do not include whether a journal is authoritative or predatory. A systematic review is itself a secondary analysis of original data with an inherent weakness: errors in interpretation of the original data are doubled. This weakness copied with uncertainties in selection criteria often makes such reviews too weak. I would trust and rely on those reports of trusted journals and trusted author teams more than on systematic reviews on the same topics. There appears to be a need to revise criteria for systematic reviews.

The above concerns might not be problems in the early 1990s when evidence-based medicine was advocated by Eddy.[2] With increases in the sources of evidence, issues of seriously analyzing the sources are critical. General practitioners often rely on "evidence" in the reports but have little insight to the information sources. Even caregivers in an academic institute may not be able to discern or easily suspect false information because of general trust on academic journals and the belief that they are strict.

As journals grow in number markedly, I see two other types of journals positioned between what are called authoritative (serious) journals and predatory journals. One includes those with excellent peer reviews and editorial process, but they lack rigorous measures to minimize publication of wrong information. Another are journals bearing some features of the predatory ones and which are run by less-trained editors; these journals have little or no capability of preventing, correcting, or retracting misinformation. I consider above

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0749-0712/22/ 2022 Published by Elsevier Inc.

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II Editorial

4 groups of journals of varying stringency exist nowadays, which are serious, dependable, lenient, or predatory journals. The latter two may have a high risk of misinformation.

Besides, clinical outcome reports may make improper or imprecise final conclusions based on correct data and correct study process. The problems often lie in the interpretation of findings and data and the wordings used. Whether these improper or imprecise conclusions are finally published depends on the quality of the editorial review process. In my experience as an editor, I have to raise questions to the authors for the wordings of conclusions or revise them myself after rounds of peer review and revisions. Sometimes the authors are ones who are quite senior, frequently published, or both. I can see that if I had not questioned or revised these conclusions, errors would be published and affect the selection of clinical methods by the readers. Clinical evidence in these reports is valid, but the interpretation of the evidence is imprecise or improper.

The best way to decrease wrong information relating to data interpretation in a report is to place much attention on checking the final conclusions. This is important because most readers would only read the conclusions, not sensibly check whether the data actually led to the conclusions. Therefore, before publication, the scope of the conclusions should be carefully scaled without overgeneralization, and limitations should be clearly presented before making any final conclusions. If expert peer-reviewers and editors fail to revise the conclusions, general readers are unlikely to do so. I have encountered several occasions in which I found that the data led to almost entirely opposite conclusions from those made by the authors. I wrote so to the authors, and they changed the conclusions.

To clearly recognize the imperfect sites where wrong information may be introduced would cause providers to be more careful in adopting "evidence" reported. Among "evidence" they read and use, some may be false at the data collection and reporting levels at the worst, which may be a small part of the literature. Some are from reliable and correct studies, but misinterpretation causes problems. Recognition would highlight the potential problems in the literature and alert the readers.

Recognition of these problems does not undermine the importance of the medical literature and the collective efforts of all involved. Rather it raises awareness of the need to clean the literature overall and to provide *correct interpretation and conclusions* in individual reports, a task of authors, reviewers, editors, and postpublication commenting. This is essential to preventing wrong information. Once a wrong conclusion is printed, it is hard to change, which is often cited to argue against the authentic evidence and weaken its impact on clinical decision making. The peer review and editorial process are not perfect and will never be. It is best to let junior colleagues know very clearly about the process' fallibility. Once printed, these articles carry a degree of authority, especially to the junior caregivers. It is often easier to critique a paper with senior academic practitioners because they examine and have insight themselves. Junior ones rely more heavily on what is printed, and consequently, the impact on them is not easily changed.

In summary, I bring hypothesis-based practice and wrong information-based practice to wide attention, and I group journals by 4 different levels of stringency. I urge colleagues to recognize these when seeking or applying evidence in delivering patient care.

Jin Bo Tang, MD
Department of Hand Surgery
Affiliated Hospital of Nantong University
20 West Temple Road
Nantong 226001, Jiangsu, China

E-mail address:
jinbotang@yahoo.com

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Member Society

ASSOCIATION OF CHINESE-SPEAKING HAND SURGEONS.

During the first three weeks of November 2022, the 17th course of Microsurgical Anatomy and Clinical Fellowship was held in Jinan, Shandong, with Dr Zengtao Wang as the course chair. This is the 17th annual event which started in 2005. The Advanced Digital Reconstruction Course was held at the same time. Attendees were able to have in-depth discussion with several master microsurgeons on flap anatomy, indications for surgical transfer and key surgical techniques.

The course also included preoperative evaluation, anatomical dissection, case discussion, and real-time surgical demonstration from the surgical theater and online streaming (Figures 1 and 2). This course has been very popular over the past 17 years, in spite of the covid pandemic.

Figures 1 and 2.
The Advanced Course of Microsurgical Anatomy and Surgical Techniques in Jinan, Shandong by Chinese-speaking colleagues in November 2022.

Published in January 2022, the popular textbook of hand surgery written in Chinese: "Hand Surgery: Classic methods and modern techniques", has become a best-selling hand surgery text with. This new 900-page textbook was edited by Dr Jin Bo Tang, with contributions from 23 hand surgeons and was published by Shanghai Science and Technology Press.

In November 2022 the Journal Club, led by Dr Andy Liu from Taiwan, was expanded to stream into mainland China and Taiwan. It was attended by about 2000 hand surgeons, which is a further increase in the number of attendees. In 2023 this Journal Club will continue, with each session lasting 1.5 hours, discussing 3 articles from recent worldwide literature.

CHILEAN SOCIETY FOR SURGERY OF THE HAND

The Chilean Society for Surgery of the Hand was an active participant of the 58th annual Chilean Orthopaedics and Traumatology Congress (SCHOT) which was held in Viña del Mar from 16 to 19 November 2022.

The hand surgeons have their independent conference rooms with a full program of hand related topics covering topics such as trauma, nerve repair, nerve entrapment, arthroplasty, flexor and extensor tendon repairs and microsurgery.

There were about 80 presentations and lectures during the three-day congress. Virtual presentations were also given by international experts. The invited lecturer was Dr Jin Bo Tang, who gave 5 lectures on peripheral nerve entrapment, flexor tendon repair, wide-awake surgery, and rehabilitation.

Lively discussions and debates were had on the size of incision of atypical peripheral nerve entrapment, the indications and patient's comfort with wide-wake surgery, the postoperative rehabilitation after tendon repair, the indications for salvage surgery for severely traumatized patients, and the indication of late joint and tendon reconstructions.

The Congress was paired with excellent social events. Many young hand surgeon colleagues had the opportunity to discuss and built connections with senior colleagues and international experts. This congress attracted many colleagues from neighboring South American countries.

MALAYSIAN SOCIETY FOR SURGERY OF THE HAND

The History of Hand and Microsurgery in Malaysia

Hand Surgery in Malaysia began as management for leprosy. A leprosarium was set up in Sungai Buloh, a suburb 15 minutes' drive from our capital, Kuala Lumpur (Fig 1). The set-up included inpatient facilities and residences for patients requiring long term management. Many patients decided to reside around the hospital to escape social stigma, and group together economically, to grow and sell flowers and potted plants. The area became known for selling plants and flowers, admittedly not an ideal occupation for those with insensate hands. Nevertheless it helped patients to make a good living and in some cases, to prosper.

Fig. 1 Sungai Buloh Leprosarium Ward.

The late Dr K. Thambyrajah was a pioneer in Malaysian hand surgery. He worked in the Sungai Buloh Hospital in the 1960s. He remembers Dr Dakshiamoorthy and himself performing 20 to 30 procedures a month on leprosy hands and feet. The main problem they encountered was the high ulnar nerve lesion. Today, leprosy is still the world's main cause of high ulnar nerve palsies. They performed Brand's many tailed transfer, as an anti-claw procedure.

They also performed opponensplasties for median nerve lesions at the wrist. Sadly, they were not able to restore the debilitating loss of sensation. We are not much better at that, even today.

Help was also available internationally, including visits from the legendary leprosy surgeon, Dr Grace Warren, from Australia. They examined and operated on patients and guided young surgeons. The Leprosy Mission of England helped by sending therapists to rehabilitate these unfortunate patients.

Dr Thambyrajah did two fellowships with Mr Pulvertaft at the Derbyshire Royal Infirmary and on his return joined the Orthopaedic Department of the University of Malaya. With encouragement from Prof P. Balasubramaniam the head of the Orthopaedic Department and advice from Prof Pesi Chacha, a visiting examiner from Singapore, a microsurgical practice laboratory was set up using the rat carotid artery model. The Department of Orthopaedic Surgery, National Orthopaedic Centre of Excellence for Research and Learning (NOCERAL) at the University of Malaya has successfully run a continuous Basic Microsurgery Course for the past 17 years educating potential micro-surgeons.

Dato' Dr. Abdul Hamid bin Kadir did a fellowship with Hand Surgeon Dr Campbell Semple in the UK. Dato' Hamid joined the second medical school in Malaysia, at the Universiti Kebangsaan Malaysia (UKM) (National University of Malaysia) and set up microsurgery there.

In 1983, he organized a Hand Surgery Course under the banner of the Malaysian Orthopaedic Association (MOA) and the College of Surgeons of Malaysia (Fig 2). The distinguished faculty included Dr S. P. Chow and Dr P. C. Leung from Hong Kong, Dr Venkataswami from India, Dr Campbell Semple from UK, Dr Chehab Helmi from Indonesia and Dr Robert W. H. Pho from Singapore. Dato' Hamid and Dr Khaw Joo Hwa represented Malaysia. Over the years, there has been much cooperation and transfer of skills from nearby

and distant countries. Dr P. C. Leung performed the first two toe-to-thumb transfers in Malaysia, (one in each of the two medical faculties) in 1985.

Fig. 2 Malaysian Orthopaedic Surgery Association / College of Surgeons of Malaysia National Course on Hand Surgery.
Left to right: SP Chow, Venkataswami, PC Leung, Campbell Semple, Chehab Helmi, Robert WH Pho, Khaw Joo Hwa, Abdul Hamid Abdul Kadir.

Over the years, many more young surgeons developed an interest in Hand and Microsurgery and several did training abroad. Dr V. Pathmanathan and Dr R. A. Vaikunthan were the first to do fellowships at the Christine Kleinert Instituite of Hand Surgery in Louisville. Kentucky, USA. After their return, enthusiasm was high and the Malaysian Society for Surgery of the Hand (MSSH) was formed. It was registered on 3 March 1993. Dato' Dr Hamid became the President and Dr V. Pathmanathan the Secretary. The motto of our Society is "Excellence through Hand Surgery".

The surgeons worked closely with therapists and decided to make therapists full members of the Society, a very unique cooperation not seen in any other country. Several therapists, especially Mr Nathan Vytialingam, were active in the committees in the early days. However, later on it was decided to revert to an association membership similar to those overseas, with surgeons as full members and therapists as associate members. We ran joint "Road-shows" with therapists, in most of the states of Malaysia, where surgeons would talk about various topics covering mainly hand trauma, and therapists would hold splinting and therapy workshops.

In 1993 the Malaysian Society for Surgery of the Hand (MSSH) organized the 1st Malaysian Conference on Surgery and Rehabilitation of the Hand (Fig 3). The guest speakers included internationally renowned therapists such as Judy Colditz, and top surgeons including Dr Robert W.H. Pho, Dr Tsu Min Tsai, Dr David Green, Dr Teoh Lam Chuan and Dr James Hunter. The next conference was entitled "The 2nd Malaysian Conference on Surgery and Rehabilitation of the Hand" but quickly became known as the "2nd Hand Meeting"!

We invited in addition to the previous regional guests, Dr Jean Pillet, the famous prosthetist, from France, and other famous hand surgeons such as Dr Venkataswami and Dr B. B. Joshi from India. It was again a very successful international meeting, although on a visit to the Tropical Jungle Learning Centre (Rimba Ilmu) of the University of Malaya, a thunderstorm broke out and a bolt of lightning struck a few feet from Prof Dr Robert Pho!

Fig. 3 1st Malaysian Conference on Surgery and Rehabilitation of the Hand in 1993.

Since those two big international conferences, the specialty of hand surgery has been slowly and quietly gaining strength. There have been circle meetings at least three times a year. These meetings are loosely based on the circle meetings held in Liverpool, UK and the concept was brought back by Master Ch. Orth. (Liverpool) candidates. The meetings are held traditionally in homes of surgeons, and are casual meetings where exchanges of ideas occur and discussions on difficult problems are held. These casual and warm meetings are in line with Malaysian culture and have been readily accepted and proved to be an invaluable source of learning and camaraderie.

Yearly annual scientific meetings are held in conjunction with the MSSH annual general meeting and have been well attended. In addition, other courses that have been held are the University of Malaya (UM) cadaveric flap course (2007), the University of Putra comprehensive course (2008), and for several years the UM Basic Microsurgery Course as well as the Kuantan National Course on Hand Trauma.

Many courses are held on a regular basis on eg. tendon repair, surgical technique, brachial plexus, and courses to introduce young doctors to hand surgery and encourage involvement in MOA meetings. In the current climate, many have learned the art of online courses and future meetings may use the "new normal" virtual format.

Prof Dato' Dr Tunku Sara Ahmad designed a logo which was adopted by the MSSH in 2007 (Fig 4). The weaving motif was used, as much food decoration and handicraft in Malaysia uses this method. This was meant to reflect the many different cultures and disciplines that are interwoven and working towards excellence in hand surgery.

The Department of Hand Surgery in the Ministry of Health was setup in the Kuala Lumpur Hospital in 1986. It moved to Selayang Hospital in 1999 and was headed by Dr V Pathmanathan, a pioneer who has been tirelessly involved in the training of Hand Surgeons since the Department was established. This Department was transferred to the Department of Orthopaedics in June 2016.

Fig. 4 Logo reflecting different cultures and discipline interwoven and working towards excellence in hand surgery designed by Prof Tunku Sara Ahmad. Based on the Malay traditional craft of weaving.

On the 18 May 2000, a team led by Dr V Pathmanathan at the Department of Hand Surgery in Selayang, performed the world's first 'arm and hand transplant' on a one-month-old baby girl from her twin, who was born with a brain which was incompatible with further life. Since the twins were identical, there was no need for anti-rejection drugs. It was also the world's 9th successful hand transplant. The child did well and has celebrated many birthdays with her doctors and medical team since then!

The Malaysian Ministry of Health started a four year subspecialty postgraduate course in Hand and Microsurgery, and the first graduates in 2011 were Dr Chuah Chee Kheng and Dato' Dr Rashdeen Fazwi.

When FESSH (Federation of European Societies for Surgery of the Hand) opened their Hand and Microsurgery examination to non-Europeans, Dr Vaikunthan Rajaratnam entered and won the Churchill Livingstone prize. Prof Dr Sharifah Roohi Syed Waseem Ahmad also topped her batch in 2008 in the FESSH exams in Lausanne, Switzerland (Fig 5). Prof Dato' Dr Tunku Sara Ahmad passed the exams in 2009 followed by Associate Prof Dr Shalimar in 2010. Malaysian hand surgeons will continue to seek international benchmarking and this may be one venue.

Fig. 5 FESSH 2008 in Lausanne, Switzerland where Prof Sharifah Roohi Ahmad received the highest marks during the FESSH exams.
Left to right: Prof Sharifah Roohi Ahmad, Prof Tunku Sara Ahmad, Assoc Prof Dr Shalimar Abdullah.

The trauma seen in our country has attracted fellows in Hand and Microsurgery from abroad such as: Dr Tracey Horton (U.K. 2006), now Consultant Hand Surgeon in Derby, UK; Dr Simon Tan (U.K. 2007), now a consultant hand surgeon in Birmingham, UK. This exchange of ideas and also culture is excellent for our local surgeons. We need to benchmark our standards with international standards. Many more Fellows have come to Malaysia since then, from several countries such as Indonesia, Iran, Bangladesh, Saudi Arabia, Turkey and Sudan.

The congress of the 10th Asian Pacific Federation of Societies for Surgery of the Hand (APFSSH) and 6th Asian Pacific Federation of Societies for Hand Therapists (APFSHT) was held in Kuala Lumpur from 2 to 4 October 2014 (Fig 6).

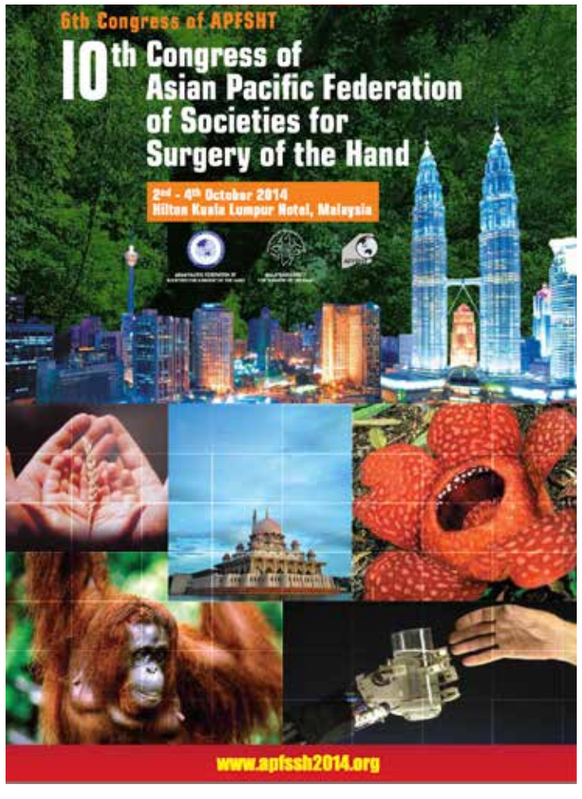


Fig. 6 Cover of programme for the APFSSH and APFSHT 2014 Meeting in Kuala Lumpur.

It was held at the KL Hilton and Meridian Hotel and was hailed by all as highly successful. There were over 1000 participants (641 delegates were from overseas) with 223 talks, 114 free papers and 98 posters. The Organising Chairperson was Prof Roohi Ahmad and the Scientific Chair was Associate Prof Shalimar Abdullah.

MSSH members try, as far as we can, to keep up with useful advances. The WALANT (Wide Awake Local Anaesthesia No Tourniquet) technique as described by Dr Don Lalonde was introduced in Malaysia in 2014 when Dr Shalimar Abdullah, as Scientific Chair, invited him as a plenary speaker for the APFSSH 2014 meeting. This meeting was a turning point as WALANT was also introduced to the Asia-Pacific region. In 2015, Shalimar was selected as the ASSH Junior Travelling Fellow and visited Dr Lalonde's practice in Canada. On her return she began practicing WALANT and taught Dr Amir Adham Ahmad, her Fellow in training (Fig 7).

Fig. 7 Amir Adham Ahmad and Shalimar Abdullah with Dr Donald Lalonde (Father of WALANT) at the IFSSH 2019 Berlin meeting.

In 2016, a well-organised and successful symposium with live surgeries was held by the Hand Unit of the General Hospital Kuala Lumpur under the auspices of the Ministry of Health and MSSH and headed by Dato' Dr Rashdeen Fazwi. There were live surgeries including wrist arthroscopy performed simultaneously in 3 operating theatres.

Dr Amir Adham Ahmad was constantly frustrated that hand surgeries were always last on operating lists and in 2018, began using hematoma blocks and evolved it to include distal radius fractures. The technique was successful and bony WALANT was born. He further expanded it to ulna, radial head, olecranon, clavicle and down into malleoli and distal tibia fractures. He published his surgical technique for distal radius fractures in the Journal of Hand Surgery (Am) 2019.

In 2018 the Society attempted to reduce the number of notoriously severe hand injuries caused by the explosions of firecrackers, especially during the Chinese New Year and Aidil Fitri celebrations. An online appeal was launched with strong pictorial deterrents. We hope this will reduce the number of injuries in the future.

Dr Rashdeen as the AO Hand & Wrist delegate for Malaysia, conducted an AO Course in Malaysia in 2019.

As the Covid pandemic began in early 2020, many courses were held online. The MSSH Annual Scientific Meeting held in March 2021 was hybrid with approximately 200 participants. At the same time, with limited inter-state movements, 6 tendon courses was held concurrently at 6 different locations throughout Malaysia with broadcasted lectures and QA sessions. In October 2021, an on-line WALANT symposium attracted a record-breaking 400 participants from all over the world followed by a hands-on WALANT workshop.

In December 2021, MSSH hosted the 2nd ASEAN Hand meeting at Kuala Lumpur Convention Centre. As the pandemic prevented international travel, it was a hybrid conference with physical participants from Malaysia and on-line participants and speakers from the ASEAN region. In 2022, a 3-day cadaveric fracture fixation, brachial plexus and flap course was held as part of the Silent Mentor programme.

Our MSSH members are also active in attending APFSSH and IFSSH meetings – APFSSH Hong Kong

in 2008 (Fig 8), IFSSH Berlin in 2019 (Fig 9) and IFSSH London in 2022 (Fig 10). Dr Hanifah Jusoh was selected as the IFSSH Fellow and was a team member in the Fellows team in the University Challenge (Fig 11). This was a fun quiz competition between Fellows versus Professors with questions on Hand Surgery and general knowledge. It was very sporting of the Professors, as it could have been quite embarrassing if they had lost, but needless to say the Professors won.

Fig. 8 Malaysian Hand surgeons and friends at the APFSSH Hong Kong (2008) posing at the hand print of Jackie Chan.
Left to right: Roohi Ahmad, Saw Kim Beng, Iskandar Mohd Amin, Tunku Sara Ahmad, Md Nawar Arrifin, Ng Eng Seng, Kamil Mohd Kasim, Shalimar Abdullah

Fig 9. Malaysian delegates in IFSSH Berlin 2019. Left to r ight : Jeremy Prakash, Chai Siau Chiu (therapist), Liew Siew Khei, Roohi Ahmad, Shalimar Abdullah, Amir Ahmad, Ruban Sivanoli, unnamed PhD student.

Fig 10. Malaysian delegates in IFSSH London 2021. Left to right: Shalimar Abdullah, Roohi Ahmad, CY Ng, Abdul Nawfar Sadagatullah, Iskandar Mohd Amin, Michelle Lim, Elaine Soh, Khoo Saw Sian, Hanifah Jusoh.

Fig 11. Dr Hanifah Jusoh was selected as an IFSSH Travelling Fellow 2021 and participated in the Fellows versus Professors Challenge. The Fellows lost but still received a token trophy.

Two emeritus members of the MSSH have been elected so far: Dato' Dr Abdul Hamid Abd Kadir (2011) and Professor Dato' Dr Tunku Sara Tunku Ahmad Yahaya (2012).

The MSSH Past Presidents so far are:

- Dato' Dr Abdul Hamid bin Abdul Kadir
- Professor Dato' Dr. Tunku Sara Tunku Ahmad Yahaya
- Professor Sharifah Roohi Syed Waseem Ahmad
- Professor Manohar Arumugam
- Dato Dr Rashdeen Fazwi Muhammad Nawawi

MSSH currently has 52 members.
The current committee for 2022 consists of:

- President
  - Dr Mohd Iskandar Mohd Amin
- Vice President
  - Dr Jeremy Prakash Silvanathan
- Honorary Secretary
  - Associate Prof Dr Shalimar Abdullah
- Honorary Treasurer:
  - Dr Shams Amir Shamsul Bahar
- Committee Member 1:
  - Dr Aniza Faizi Anoar
- Committee Member 2
  - Dr Ruban Sivanoli
- Committee Member 3
  - Dr Mohamad Sallehuddin Hassan
- Committee Member 4
  - Dr Vijay Gopal
- Auditor 1
  - Professor Dr Sharifah Roohi Syed Waseem Ahmad
- Auditor 2
  - Professor Dato' Dr. Tunku Sara Tunku Ahmad Yahaya

The aims of the MSSH are

- to have a uniformly high standard of care for hand conditions and injuries throughout the country, by training a sufficient number of good specialists.
- to have a high standard of local postgraduate training in hand and microsurgery.
- to aid, catalyse and foster formation of hand therapists groups for training and learning, nationally and internationally.
- to form and maintain closer international links in the subspecialty.
- to carry out more useful cutting edge research.
- to look into prevention and treatment of hand injuries in the local context.
- to be a presence at all international conferences.
- to publish pioneering work in all major hand surgery journals.

Our web address : http://www.mssh.org.my/about_us.html

ASSOC PROF DR SHALIMAR ABDULLAH
Consultant Hand & Microsurgeon
Faculty of Medicine
Universiti Kebangsaan Malaysia (UKM)
Kuala Lumpur
Malaysia
Email: kelapa44@yahoo.comDaniel.Herren@kws.ch

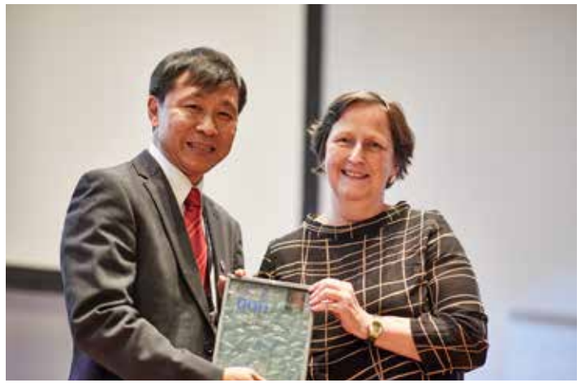
PROF TUNKU SARA TUNKU AHMAD YAHYA
Honorary Professor
Faculty of Medicine
University of Malaya
Kuala Lumpur
Malaysia
Email : tsarazmail@yahoo.co.uk

GERMAN SOCIETY FOR HAND SURGERY (DGH)

Despite the Corona pandemic with all the necessary restrictions, the German Society for Hand Surgery (DGH) was able to organize its annual congress every year with in-person presence in 2020 obviously with a reduced capacity of only 541, in 2022 with 722 and this year with 870 participants in the Bavarian town of Garmisch Partenkirchen. Our past-president Dr. Eva-Maria Baur hosted the congress. Major topics during the scientific sessions were "disorders of the children's hand" and "treatment options in CMC-1 arthritis". This year's guest society was the Hong Kong Society for Surgery of the Hand and it was a pleasure and an honor to host our guests. They made a huge effort to join us despite the restrictions due to the Corona pandemic. Prof. PC Ho presented the honorary Buck-Gramcko lecture. The congress dinner and party were organized in typical Bavarian fashion.

At the general assembly the president-ship was passed over from Prof. Max Haerle from Markgröningen to Dr. Wiebke Hülsemann from Hamburg, and Prof. Martin Langer from the city of Münster was elected President-elect. The DGH is a continuously growing society with 1234 members in 2021, 1267 members in 2022 and 1373 members in 2023.

This year our Society has establish a national certificate called "Hand Expert" to motivate our members on continuous education and qualification.



So far, 71 members met all the qualifications to gain this certificate. Another project of the Society was initiated in 2014 with the establishment of a "Hand Trauma Register". After 4 years of development, data collection started in 2018. By now 60 hand units providing hand trauma care are participating in the register. They describe and document specific injuries in a standardized way.

This data is collected in the register. Next year the amount of data would allow the first scientific evaluation.

This year the executive board has implemented a new committee to evaluate existing patient reported outcome measures (PROMs) concerning their validation in the German language with the aim to establish certain PROMs as a standard evaluation of all our patients in Germany.

Finally, many German hand surgeons and therapists took the chance and enjoyed to meet friends from all over the world during the IFSSH/IFSHT Congress in London and we are glad to be part of the Hand-World.

PROF. DR. JÖRG VAN SCHOONHOVEN
Secretary General of the German Society for Hand Surgery (Deutsche Gesellschaft für Handchiurgie DGH)

NEW ZEALAND HAND SURGERY SOCIETY

IFSSH Meeting London 2022: The Flying Kiwis visit

Well the days of taking international conferences for granted are well and truly over.

This was the first international meeting that a lot of us in the Southern hemisphere have managed to attend. Flights are more expensive and in short supply, and with crosslink works and tube strikes to contend with the challenge were there. However no matches for the draw of an excellent meeting and to top it off the Queen's Platinum Jubilee!

The view from the London Cable Car travelling from the venue.

We have to congratulate the organisers for what was an amazing meeting in such turbulent times. Having to test negative for Covid for the flights there and home meant extra diligence on our part, although at least one of our contingent succumbed and spent most of the time isolating.

The lectures were superb and it was sometimes a difficult choice of which of the many to attend. The themes of management pathways, advancing techniques in arthroplasty, and nerve transfer are taking our profession to new levels. We look forward to being able to visit again and contribute to the increasing strides being achieved.

The dedicated contingent that made it to the Congress is part of our New Zealand Society for Surgery of the Hand which currently stands at 105 members from both an Orthopaedic and Plastic Surgical backgrounds. The Executive committee currently comprises: President Chris Lowden, Secretary Robert Rowan, Past President Tim Tasman-Jones, Past Secretary Sandeep Patel, President Elect Jeremy Simcock and Secretary Elect Allen Cockfield.

Chris Lowden (with Loupes) being photo bombed while trying to make a dent in the waiting list

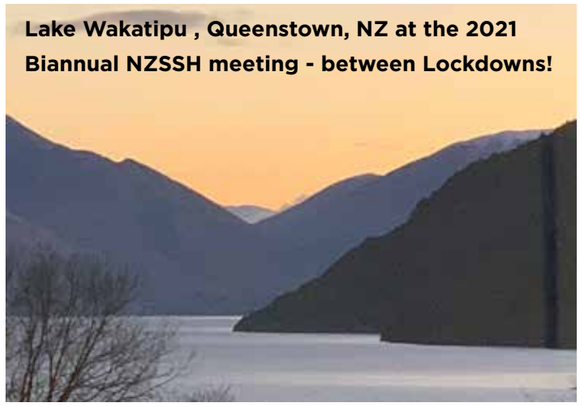
During our "Fortress New Zealand" Covid isolation in July 2021 we did manage to hold our annual NZSSH meeting which we ran back to back with the NZ Shoulder and Elbow Society in Queenstown between lockdowns. The enforced absence of International Speakers meant that out of necessity we had to "step up" and it definitely drew us closer together as a Society.

During the peaks of the outbreak our national pandemic response led by the now Sir Ashley Bloomfield was very much a proactive containment philosophy and as such there were a number of complete (as we call it "Level 4") lockdowns. This meant home isolation for the majority of people, and therefore with cancellations of elective surgery on a national level. With the already burgeoning waiting list this has meant we are still facing an uphill struggle for our patients. Similar challenges are faced in Australia and I am sure elsewhere in the world.

Albert Yoon (NZHSS member, Auckland) at the 2022 London Congress with then IFSSH President, Marc Garcia-Elias, and IFSSH Administrative Secretary, Belinda Smith.

On a much brighter note, we have just had the joint meeting between NZSSH and NZ Association of Plastic Surgeons in Wellington which was a great success and we extend our sincere appreciation to our International (Australian) guest speakers - Anthony Berger for his amazing presentations and Greg Bain for his virtual contributions.

Hopefully 2023 will bring some more stability and allow us to to help ease the growing number of patients on our elective waiting lists around the world. Planning at this stage for our next NZSSH meeting in August in Queenstown is well under way which will be a combined meeting with the NZ Orthopaedic Association Congress. We hope to see you there!



Lake Wakatipu , Queenstown, NZ at the 2021 Biannual NZSSH meeting - between Lockdowns!

Chris Lowden
President NZSSH

PERUVIAN ASSOCIATION OF HAND SURGERY AND MICROSURGERY

Peru: First Congress of Hand Surgery and Microsurgery.

Group of foreign teachers

The First Hand Surgery Congress of Peru was held with great success from 13-15 October 2022. After 7 years of hard work our young Society has grown daily, and with the desire to also contribute to hand surgery international, we pulled off our first national meeting.

Having already held important scientific events in previous years, our first congress stood out with the participation of 168 attendees and several Peruvian exhibitors, as well as foreigners doctors from Ecuador, Spain, Argentina, Brazil, Colombia, Mexico, Costa Rica, Guatemala, and Venezuela.

In addition to the scientific exhibitions related to hand surgery and it's rehabilitation, an important commercial exhibition of products aimed at complementing the treatment of hand injuries could also be seen.

Within the main event, a complete IBRA (International Bone Research Association) module on the management of hand and wrist fractures was held for the first time in Peru. Likewise, there was an important international segment on wrist arthroplasties, which was well atended.

The organiser of this Congress was Dr. Mirko Tello Vinces, President of the Peruvian Association of Hand Surgery and Microsurgery. A new Board of Directors was chosen at this meeting.

Also for the first time a group of 5 new young Peruvian Hand Surgeons who trained abroad were chosen as Associates, thus achieving one of the objectives of our Association.

We are especially grateful to all our foreign hand surgeon friends who participated unconditionally, giving and sharing their experience to 'feed' hand surgery in Peru.

See you in the next congress!

Members of the APCMM: Dr. J.J.Rodriguez, Dr. J. Coronel, Dr. J. Vidanggos, Dra. Mariana Pendavis, Dr. Mirko Tello, Dr. C. Lozano, Dr. A. Mena, Dra. L. Marroquín, Dr. B. Pietrapiana, Dra. R. Olivos, Dra. Ana García

Dr. Mirko Tello (President of APCMM) y Dr. Joaquim Casañas (Past President of SECMA)

Dra. Mariana Pendavis, Dr. Orlando de La Cruz, Dr. Fidel Cayón, Dra Aida García, Dr. Luis Naquira, Dr. Mirko Tello, Dr. Juan Ramón Bonfil.

POLISH SOCIETY FOR SURGERY OF THE HAND (PSSH)

Poland was severely influenced by two major factors during 2022: The Russian invasion of Ukraine, a Polish neighbouring country, and the removal of nearly all COVID-19 restrictions.

Russia's unprovoked invasion of Ukraine in 2022 has set alight one of the bloodiest conflicts in Europe since World War II. Millions of refugees from Ukraine have crossed borders into Poland and neighbouring countries, and many more have been forced to move inside the country. To help Ukraine cope with the skyrocketing medical needs, Poland has received medical evacuations through the MEDEVAC transfer scheme.

In addition, the PSSH arranged for sponsored donations of surgical equipment to Ukrainian hospitals valued at PLN141563 (US$ 32 173), thanks to industry sponsorships.

We also donated US$ 3000 to the Ukrainian Hand Society as financial support for their increased activity due to the war casualties.

The removal of nearly all COVID-19 restrictions allowed the PSSH to focus on boosting scientific, research and educational activities. And, as we continue the new 'virtual' normal, there were also opportunities to get together again, to share knowledge and to do networking.

The following are some of our 2022 highlights:
The XIV International Poznan Course: Upper Extremity Surgery: Forearm, Wrist, and Hand organized by the Orthopaedic and Hand Surgery Clinic in Poznan has attracted over 200 hand surgeons and hand therapists form Poland and abroad. An intensive schedule of lectures, interactive discussions, case studies, and workshops gave participants unique insights into today's most effective techniques for treating hand, wrist, and elbow injuries. The course's international faculty comprised leading experts: Christian Dumontier (France), Lorenzo Garagnani (UK), Nicola Goldsmith (UK), Leila Harhaus (Germany), PC Ho (Hong Kong), Jonathan Hobby (UK), Steven Hovius (Netherlands), Radek Keberle (Czech), Gerald Kraan (Holand), Artur Bezuhlyi (Ukraine), Andrii Lysak (Ukraine), Michael Mak (Hong Kong) and Jin Bo Tang (China). In addition, a "Techniques of Microsurgical Reconstruction" session was delivered by The Polish Othoplast Society, a new medical society, which provided ideas on the reconstruction with microsurgical techniques.

The immersive 3rd "Summer School of Hand Surgery " was designed to allow collaboration in small group, direct interactions with an instructor and learning from peers.

The spring and autumn workshop of the "From Approaches to Reconstruction" cadaver course, founded in 2017, continues to provide a valuable forum to practice with more experienced colleagues to mentor younger members of the PSSH. The spring workshop was highlighted by Prof. Leila Harhaus (Germany) as one of the instructors.

And finally, the webinar series (6) delivered by local and internationals speakers has proven to be popular and has become a 'favourite regular' on The PSSH educational calendar.

Our XII PSSH Congress this year will be held in Czestochowa, a Polish town in Silesia, in combination with the Polish Society for Hand Physiotherapy Congress.

We are moving forward into 2023 with excitement and forge on, prepared to tackle what may lie ahead.

Ireneusz Adam Walaszek
MD PhD
Hand Diploma FESSH
IFSSH Delegate for the Polish Society for Surgery of the Hand

MEXICAN ASSOCIATION FOR SURGERY OF THE HAND

Asociación Mexicana de Cirugía de la Mano A.C.
XII Annual Hand Surgery Meeting

Faculty of the XII Annual Hand Surgery Meeting of the AMCM in Guadalajara Mex from all over Latin America, Spain and Italy.

The Mexican Association for Surgery of the Hand held it's XII Annual Hand Surgery Meeting from 9-12 November 2022.
Given the lowered COVID-19 restrictions, the meeting was 100% in-person, and we had the opportunity to listen to lectures from the top hand surgeons from Latin America, Spain and Italy. The topics focused mainly on wrist and hand arthroscopy, complex trauma, and carpal reconstructions.

Dr Marc García Elias lecturing on carpal biomechanics

The new board members for the 2022-2024 term of the AMCM were elected during the Meeting with Dr Joaquin Diaz the new President.

The Board has a new division: Continuous Medical Education under the guidance of Dr Aldo Beltran, Dr Yadira Bahena, Dr Ubaldo Ayala, Dr Ignacio Bermudez, Dr, Jorge Luna and Dr Gilberto Herrera.

Dr. Joaquin Díaz- President, Dr Juan Ramón Bonfil - Past President, Dr Francisco García- Vice President of the AMCM

Funny moments: The Vice-President of the AMCM Dr Francisco Garcia presented the exiting Board with Luchador masks, thanking them for their efforts!.

Some of the faculty at our Meeting:
Back row: Dr Gilberto Herrera, Dr Matías Sala, Dr Francisco Garcia, Dr René Jorquera, Dr Juan Ramon Bonfil, Dr Vicente Carratalá, Dr Pedro Delgado, Dr Martin Caloia.
Front row: Dr Joaquin Díaz, Dr Andrea Atzei, Dr Joaquim Casañas and Dr Mirko Tello

Humanitarian surgical missions (Campaña de cirugía extramuros)

As a tradition in our Association, the altruistic surgical missions take place in rural and semi-rural towns where the access to hand surgery is difficult or non existent. The patients get access to medical care and surgical procedures free of charge.

Under the leadership of Dr Victor Azpeitia the director of altruistic missions, and alongside with the health authorities of Baja California the last mission of 2022 took place in San José del Cabo.

Thirty-eight patients received surgery for different conditions; 12 of those where children. Eleven hand surgeons from all over the country along with general and orthopedic surgical residents attended the call of Dr Azpeitia to get the mission done.

The surgical team gathered by Dr Victor Azpeitia in Baja California Sur after a few days of hard work.

The team of hand surgeons, residents and medical students attended the information meeting with local health authorities in Baja California Sur.

ECUADORIAN SOCIETY FOR SURGERY OF THE HAND (ECUMANO)

For the Ecuadorian Society for Surgery of the Hand, 2022 was an important year. In February 2022 we held our very first Congress.

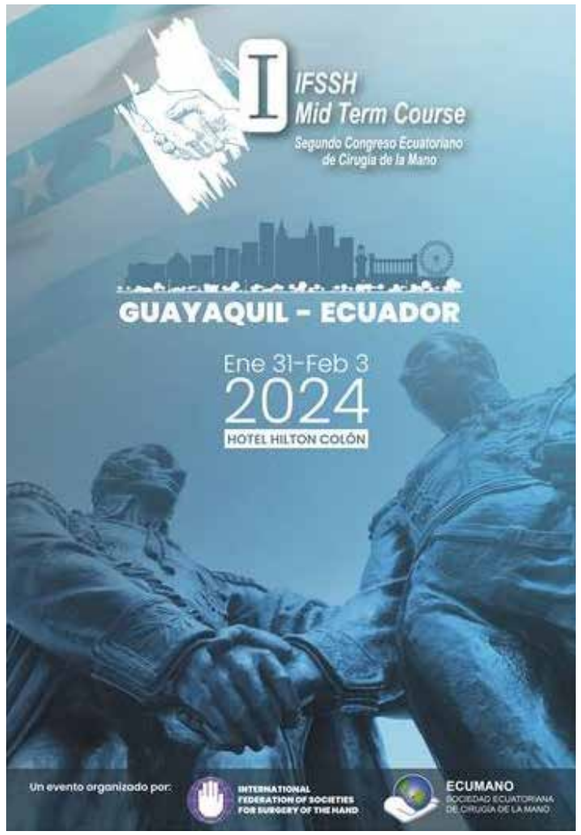
The success of this Meeting exceeded our expectations! Delegates from all over Latin America attended as well as delegates from other countries. We are proud to be counted now as one of the international Member Societies, being in the 'centre of the planet'!

At the last IFSSH Congress in London in June 2022 we presented our bid to host the First IFSSH Mid-term Course, and won the privilege!

This newly established IFSSH Course will be held in Guayaquil from 31 January – 3 February 2024. Please diarise this date!

During the COVID-19 pandemic ECUMANO achieved an important virtual presence all around Latin America throught the organisation of webinars and virtual courses with many hand surgeons participating.

Fortunately, 2022 saw a reduction of the pandemic and the restrictions which allowed us a quick and effective integration into the face-to-face world. We participated as a Society in many international congresses eg. supporting in the organization and development of the first Peruvian Congress of Hand Surgery, in the Colombian Congress of Hand Surgery and in the national congress of the Mexican Association of Hand Surgery, thus consolidating the presence of ECUMANO in Latin America.



LATIN-AMERICAN FEDERATION OF SOCIETIES FOR SURGERY OF THE HAND

(Federacion Latino-americana de Chirugia de la Mano – FLACM)

The Latin-American Federation has experienced a very active year due to the multiple meetings and congresses in our region. This was possible because of the return to in-person meetings. Furthermore, many Societies had combined Meetings, new Societies were established and the development of hybrid meetings and webinars allowed many more members to participate.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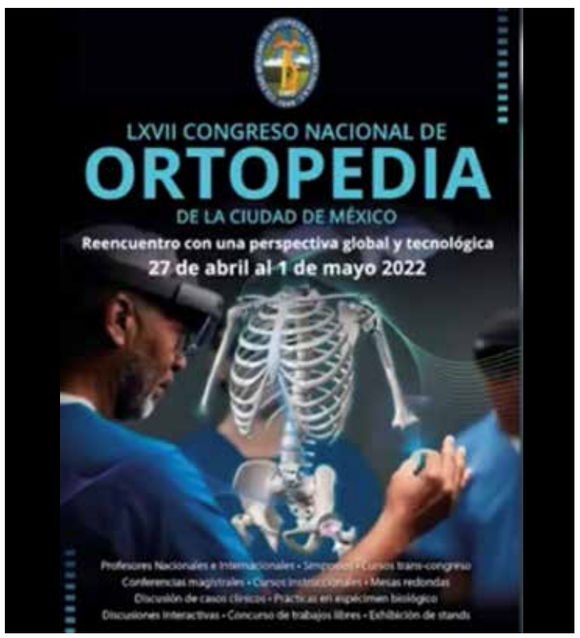
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12 al 14 de Octubre, 2022
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23° Congreso Argentino de Terapia de la Mano
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Buenos Aires, Argentina
www.aacmyrms.org
www.aacm.com.ar/cursos/congreso2022/


JORNADA DE LA FEDERACIÓN LATINOAMERICANA DE CIRUGÍA DE LA MANO "JOSÉ MARÍA ROTELLA"
Lesiones de la Mano en Atletas y su Manejo
WEBINAR
1. Metacarpal fractures in athletes
Dr. Steve Shin
2. Lesiones del Semilunar-Piramidal en golfistas y tenistas como causa del dolor cubital en la muñeca
Dr. Alejandro Badia
3. Lesiones de la mano en escaladores deportivos
Dr. Sergio Daroda
4. Trauma del miembro superior en ciclistas
Dr. Julio Sandoval
08 de septiembre de 2022
19:00 hrs. (Zona Horaria Colombia)
Transmitido por
LIVE @asocimano
Dr. Alberto Rojas
MODERADOR
Dr. Alejandro Badia
Dr. Steven Shin
Dr. Sergio Daroda
Dr. Julio Sandoval
Dr. Alejandro Espinosa Gutiérrez
Presidente de la FLACM
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JORNADA DE LA FEDERACIÓN LATINOAMERICANA DE CIRUGÍA DE LA MANO "JOSÉ MARÍA ROTELLA"
Alternativas terapéuticas en síndrome de túnel del carpo
WEBINAR
1. Manejo Conservador de Túnel Carpiano:
Dra. Paula Vindas
2. Cirugía de liberación de Túnel del Carpo: Mi preferencia y otras técnicas
Dr. Pablo Rotella
3. Cirugía de revisión de Túnel Carpiano
Dr. Antonio Carlos Da Costa
4. Síndrome de Túnel Carpiano Evolucionado
Dr. Cristhian Castro
11 de octubre de 2022
18:00 hrs. (Horario de México)
Transmitido por
zoom
Dr. Cristhian Castro
COORDINADOR
Dr. Antonio Carlos Da Costa
Dra. Paula Vindas
Dr. Pablo Rotella
Dr. Alejandro Espinosa Gutiérrez
Presidente de la FLACM
https://fedscm.org/sociedades-miembros/

During the IFSSH, IFSHT & FESSH Combined Congress London 2022, Latin America was present with a large group of teachers and assistants who participated in this great event.

In addition, the Latin-American Federation of Hand Surgery in collaboration with the Panamanian Association of Hand Surgery, showed that commitment and a collaborative effort can be achieved when there is the will and willingness to work together for the development of hand surgery in our region. It is the bond of friendship and fraternity that manages to bring together those of us with a genuine interest in academic development and dissemination of knowledge.

With an academic program that included master lectures, debate forums, updates and techniques in development, as well as workshops in which some of the main leaders in Latin American hand surgery participated, the experience and feedback from the attendees was very positive.

The historic center of Panama City was the ideal setting to complement a great scientific and social program. The face-to-face camaraderie was much-needed, and it strengthened our ties with the delegates from 10 countries.

Thank you very much to everyone who made this great event possible with their participation.

Do not forget that you are all invited to the XIX Latin-American Congress of Hand Surgery to be held in the City of Guadalajara, Mexico, from 6 to 11 November 2023. It will be a great event not to be missed.

VENEZUELAN SOCIETY FOR HAND SURGERY AND UPPER LIMB RECONSTRUCTION (SVCMRMS)

On 11 January 2023 the Venezuelan Society for Hand Surgery and Upper Limb Reconstruction (SVCMRMS) celebrated its 49th year.

On 11 January 1974 under the inspiration and tutelage of Dr. Ricardo Sánchez Beaujon, 9 Orthopedic Surgeons and Hand Surgeons met in the "saloncito – escuela" of the Hand Surgery Service of the Dr. Miguel Pérez Carreño Hospital, to found this Society.

During these past 49 years, a number of milestones have been achieved. In 1975 the 3 year postgraduate university course in Hand Surgery and Upper Limb Reconstruction, endorsed by the Central University of Venezuela, was established.

The first class of 4 specialists graduated in 1978. Since then this course has uninterruptedly produced hand and upper limb surgeons who practice throughout our country and some abroad.

This postgraduate course has now been duplicated in other states of Venezuela. In Zulia, the postgraduate course is endorsed by the University of Zulia (LUZ) and directed by Dr. José Rafael Camarillo Morillo. In the state of Carabobo, the course is directed by Drs. Fiesky Nuñez and Rafael Brunicardi, and in Caracas, at the University Hospital, the course is directed by Dr. Antonio De Santolo.

Graduates from these courses have established their own postgraduate courses which are endorsed by their local universities: at the Military Hospital of Caracas, by Dr. Carlos Arvelo, in Puerto Ordaz by Dr. Aloha Isea, at the Uyapar Hospital by Dr. Nohelia Flores, and in Barcelona the postgraduate course at the Dr. Luis Razetti University Hospital is directed by Dr. Jesús Hernández. All these courses and established centres have contributed to the rapid growth of our Society.

At the Children's Orthopedic Hospital of Caracas a Hand Surgery Unit was established on1 June 1992 for the care of pediatric patients, and especially for the study and treatment of congenital differences of the hand and upper limb. This unit has now completed 30 years of uninterrupted care and teaching. Since 2015 it offers an advanced course in the management of congenital conditions of the hand.

We are happy to share this brief history of our Society, and are proud of the achievements so far in promoting the care of the hand in Venezuela.

DR. RODOLFO CONTRERAS GAMBOA

IFSSH FELLOWSHIP PROGRAM

REPORT

IFSSH Fellowship Program

(IFSSH CONGRESS, LONDON 2022)

The IFSSH Congress in London in June 2022 saw the launch of the inaugural IFSSH Fellowship Programme. Thirty young hand surgeons from around the globe visited UK hand surgery centres of excellence for two weeks and then travelled to London to attend the Congress

Photo 1: Group shot of the IFSSH fellows at The Royal College of Surgeons England.

This Federation was formed in 1966 to coordinate the activities of the various national Societies for Surgery of the Hand throughout the world and in this way to increase and spread knowledge of surgery of the hand. The Organising Committee agreed early in the conference planning process that a Fellowship Programme would meet a founding IFSSH objective in furthering hand surgery practice and education worldwide and would forge a new network of international connections and friendships. Aligned with the ambition to have a truly global congress was the intention to include surgeons from a range of high-, low- and middle-income countries. This of course required significant financial investment and we were very grateful to IFSSH, FESSH, BSSH, BAPRAS and BFIRST for answering Mr Jonathan Hobby's calls for sponsorship.

In Summer 2020 a Fellowship Subcommittee was formed of Stephen Hodgson, Wee Leon Lam, Jonathan Hobby and Jonathan Jones and they were joined by members of the IFSSH Young Hand Surgeons Committee; Helen Wohlgemut, Alison Kinghorn, Rowa Taha, Ted Welman, Rob Miller and Lynette Spalding. Several members of the committee had longstanding involvement with BSSH international outreach projects, and their experience proved invaluable: both in the practicalities of international guests and in creating a broad and inclusive application process. The emerging COVID-19 Pandemic raised challenges at every stage of the planning process, and travel uncertainty remained a constant feature.

A competitive application process was opened in summer 2021, aimed at surgeons within three years of independent practice (the equivalent of either senior trainees or new consultants), bearing in mind the very varied training routes for hand surgery between different countries. This was advertised online in addition to being sent to all international hand Societies for distribution, plus any known contacts in countries without formal hand Societies. All applications were marked by members of the committee based on a standardised marking scheme. The high standard of candidates was very clear.

Hand surgery units across the UK were invited to express interest in hosting the fellows. To provide the greatest range of experience, successful units were paired and then worked together to provide bespoke educational and social programmes. The Jubilee weekend fell between the Fellowships and the IFSSH Congress which gave an ideal opportunity to bring all fellows together in London for the Bank Holiday weekend celebrations.

Photo 2: Teaching Day at the Royal College of Surgeons England.

The 21st May came round, and excited fellows flew from around the globe to start the program (MAP 1). Units from around the United Kingdom enthusiastically hosted the future leaders in hand surgery (MAP TWO) The fellows indicated their sub-speciality interests and were successfully matched to pairs of units that matched their educational interests. Where possible the pairs of units were geographically close and offered complimentary experience with one-to-one teaching, training, and mentorship. Host units were chosen throughout England, Scotland, and Wales. The host surgeons did an excellent job of organising educational and social programmes. We are very grateful to the many people who worked to make the placements productive and enjoyable. The feedback from the Fellows has been excellent.

The Fellows spent two weeks observing what hand surgery has to offer in the United Kingdom. Perhaps one of the most exciting opportunities of this program was the opportunity to network and make friendships with hand surgeons from around the world.

Photo 3: Shot at Tower Bridge on the Tourist Day Arranged by Ted and Rob.

Following the various fellowships around the country the Fellows travelled to London for a packed program before the IFSSH Congress. An educational morning was held at the Royal College of Surgeons England. Here the Fellows had teaching on brachial plexus and congenital hand conditions by Wee Lam, Gill Smith, Cy Ng and Dominic Power, leading experts within their fields in the United Kingdom and further afield. That evening, after a beautiful walk along the Thames River in the (thankfully) sunny London, the fellows attended a private dinner arranged by Lorenzo Garagnani at The Ivy Tower Bridge. This was an excellent evening with fine dining and even better company.

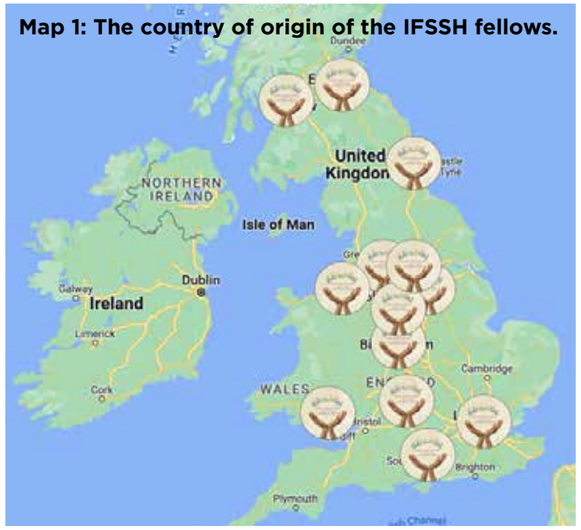
Map 1: The country of origin of the IFSSH fellows.

Ted Welman and Rob Miller designed an excellent tourist day, starting off with coffee in Notting Hill, walking along the beautiful canals in Little Venice, through Hyde Park, past Buckingham Palace to give a quick wave to Queen Elizabeth. A pit-stop for shopping in Knightsbridge, stop off at Trafalgar Square, blinded by the neon lights in Piccadilly Circus, ending up in Camden for a casual dinner. All the Fellows enjoyed the British hospitality, developed new friendships, and got a flavour of the bustling city of London.

The IFSSH Congress London 2022 started the week beginning 6th June. It has been one of the first face-to-face international meetings in hand surgery for many of us. The Fellows were able to enjoy a free registration to hear all the wonderful presentations, to attend the gala dinner, to network and for many of them, to present their own research. The Fellows were presented at the closing ceremony, where the Fellowship Program was recognised as being a jewel in the crown of the London 2022 congress, and we all hope the legacy of it continues.

Photo 4: Closing Ceremony at the IFSSH Congress. All the Fellows receiving their certificate.

We are thankful for so many things: for the funding to support the program, for all the people who helped arrange the Fellowship, for the opportunity to meet following the pandemic and most of all to meet the Fellows, who are an amazing, dynamic group of young people. They are the future of hand surgery, and the future looks so bright. So over to our wonderful friends and colleagues in Washington USA, we can't wait to see you at IFSSH 2025!



HELEN WOHLGEMUT
Plastic Surgery – Glasgow, UK
Mob: 07811 951735
helen.wohlgemut@ggc.scot.nhs.uk

ALISON KINGHORN
Plastic Trauma and Orthopaedics, Wales Deanery.
afkinghorn@gmail.com

Art Exibit #16

"Empathy; you're not alone"
Artist: unknown
Acknowledgement: "Psychiatry with Soul"

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MONIQUE ACEVEDO
monique.a.acevedo@gmail.com
+1 626 993 4025

MARÍA FERNANDA SANDOVAL
fernandasandovalrojo@gmail.com
+ 52 33 3579 2405

Mielina Clínica Plexo
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