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Training in Hand Surgery: a personal view

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

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

Hand surgery societies followed in other countries. The International Federation of Societies for Surgery of the Hand (IFSSH) was founded in Chicago in 1966 and now houses the societies of 56 countries. We celebrated our 50th birthday in Buenos Aires in 2016. Many of these societies have a close affiliation with orthopaedic surgery groups, many with plastic surgery groups and some with general surgery groups. Nevertheless, there has been a natural tendency for societies to attract members from disparate surgical backgrounds because of their common interest in conditions pertaining to the hand.

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

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

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

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

If anything, there has perhaps been a move away from the concept of the hand surgeon treating all parts of the hand anatomy. The concept of the orthopaedic upper limb surgeon treating the shoulder, elbow and wrist, with an emphasis on elegant arthroscopic technology, has taken hold. This is very much, though not absolutely limited to, the field of an orthopaedic surgeon. A plethora of shoulder/elbow, wrist and arthroscopic associations and societies are flourishing. In the meantime, whilst some aim to proceed to hand surgery or other sub-speciality fields through the plastic surgery pathway, many plastic surgery trainees trend towards a future in cosmetic surgery. Perhaps market forces in capitalist countries may create an adequate balance.

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

Michael Tonkin
Immediate Past President: IFSSH
Deputy Editor: IFSSH Ezine
SECRETARY-GENERAL REPORT

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

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

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

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

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

Finally, I believe accurate communication is extraordinarily important to achieving the mission of the IFSSH. It is not difficult to send an email but to send an email that is clear, concise and unambiguous takes some thought. I will always endeavor to abide by this precept. If ever I do not achieve this goal please let me know.

I look forward to an exciting three years as your Secretary General. Thank you for the privilege.

IFSSH Newsletter

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

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

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

The triennial IFSSH Congresses are as follows:

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

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

Best regards,

Daniel Nagle MD
Secretary-General, IFSSH

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Daniel Nagle MD
Secretary-General, IFSSH
W. Bruce Conolly
1st February 1935 - 21st February 2017

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

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

Bruce Conolly was appointed as Associate Professor of Hand Surgery at the University of New South Wales in 1992, Clinical Associate Professor of Hand Surgery at the University of Sydney in 1993, and Adjunct Professor at University of Notre Dame in 2011. He was President of the Australian Hand Surgery Society from 1995 to 1997, and President of the Asian Pacific Federation of Societies for Surgery of the Hand from 2009 to 2012. Other awards include:
- Appointment to Member of the Order of Australia in 1994
- The Archie Telfer Prize for Outstanding Service, Sydney Hospital, 1975, 2000
- Humanitarian of the Year Award, Variety Club, 2002
- IFSSH Pioneer in Hand Surgery, 2007
- Royal Australasian College of Surgeons Award - Excellence in Surgery, 2008

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

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

Members and friends of the Australian hand surgery community.
GIORGIO A BRUNELLI, 
MD

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

Professor Brunelli has been on the cutting edge of orthopaedic and hand surgery in Italy where he organized the specialities of hand surgery in 1952 and of microsurgery in 1964, performed the first total hip replacement in 1964, and the first re-implantation in 1973. He has developed many surgical techniques and performed around 25,000 operations including 1,000 brachial plexus repairs. He has been doing research on paraplegia for more than 20 years and had the first paraplegic patient walking in 1997.

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

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

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

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

DONAL M. BROOKS 1917-2004
MRCS and FRCS(Eng); BA Dublin; MB BCh BAO; MA; FRCSI; LRCP

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

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

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

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

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

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

At the Seventh International Congress of the IFSSH in Vancouver, B.C., Canada in 1998, Donal M. Brooks was honoured “Pioneer of Hand Surgery”
Carpal instability is difficult to classify. Many diverse clinical conditions may result in an unstable wrist for which different classifications have been suggested. Carpal instability has been classified based on seven parameters:

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

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

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

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

<table>
<thead>
<tr>
<th>Category I</th>
<th>Category II</th>
<th>Category III</th>
<th>Category IV</th>
<th>Category V</th>
<th>Category VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronicity</td>
<td>Constancy</td>
<td>Etiology</td>
<td>Location</td>
<td>Direction</td>
<td>Pattern</td>
</tr>
<tr>
<td>Acute &lt; 1 week (Maximum primary healing potential)</td>
<td>Predynamic</td>
<td>Congenital</td>
<td>Radiocarpal</td>
<td>VISI rotation</td>
<td>Carpal instability dissociative (CID)</td>
</tr>
<tr>
<td>Subacute 1-6 wks (some healing potential)</td>
<td>Static</td>
<td>Neoplastic</td>
<td>Distal intercarpal</td>
<td>Carpal instability</td>
<td>Carpal instability non-dissociative (CIND)</td>
</tr>
<tr>
<td>Chronic &gt;6 wks (little healing potential)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The table represents a simplified classification and does not cover all possible forms of carpal instability.
**SCAPHOLUNATE DISSOCIATION**

**Introduction**

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

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

**Anatomy**

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

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

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

In a study by Elsaidi et al, the authors found that after sequential sectioning of volar ligaments and the scapholunate interosseous ligament, no scapholunate diastasis or excessive scaphoid flexion occurred. After dividing the dorsal intercarpal ligament, scapholunate instability occurred without carpal collapse. With detaching the dorsal radiocarpal ligament from the lunate, a dorsal intercalated scapholunate instability deformity ensued.

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

**Figures**

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

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

**Figure 3: Scaphoid rotation and flexion**

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

There are other factors that also determine carpal kinematics. For example ligamentous laxity and carpal morphology affect carpal kinematics.12 The lunate morphology determines the kinematics of the normal scaphoid, and the abnormal scaphoid.12-16 Viegas et al classified lunate morphology as either type 1 or 2, according to the number of facets (one or two, respectively) present on the midcarpal surface of the bone. Lunate type is associated with carpal pathology. Type 1 lunate wrists have a higher incidence of Dorsal Intercalated Segment Instability deformity in the setting of scaphoid non union, and type 2 lunate wrists are associated with proximal hamate and scapho-trapezial-trapezoidal joint degeneration. Lunate morphology is associated with differences in the ligamentous anatomy and the kinematics of the corpus, particularly in the central carpal column (radius-lunate-capitate)11,12 (Figure 2).17

**Pathoanatomy**

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

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

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

Imaging

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

Plain Radiographs

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

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

Cineradiography

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

Arthrogram

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

Figure 5: Dislocation classification, the spectrum of radiocarpal dislocations that can occur. These include the greater arc (1), lesser arc (2), intra-lunate arc (3) and the inferior arc (4). 17

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

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

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

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

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

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

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

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

The scapholunate instability test of Watson et al. can be performed under fluoroscopy or arthroscopic vision (or both) (Figure 12). Abnormal widening of the scapholunate interval and subluxation or dislocation of the scaphoid over the dorsal rim of the distal radius can be identified. Lunotriquetral instability can also be assessed by use of the same arthroscopic assessment techniques and specific provocation tests. Pressure is placed directly onto the pisiform and on the dorsal aspect of the lunate. By squeezing the lunate volarly and the triquetrum dorsally, lunotriquetral instability is identified. The wrist is taken through radial and ulnar deviation with direct visualization of the lunotriquetral articulation.

Arthroscopy

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

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


42. McLean J, Turner, PC, Bain GI, Rezaian N, Field J,
Dear Colleague:

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

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

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

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

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

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

Survey link: https://bsb.qualtrics.com/jfe/form/SV_ITYIFdxg28QSfb

Many thanks,

Aletse de la Torre, Jason Arora, Monique Ardon, Christianne Van Nieuwenhoven and Branavan Sivakumar

On behalf of the ICHOM Congenital Hand and Upper Limb Malformations Working Group
Visit to Komfo Anokye Teaching Hospital

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

KATH is a 1200-bed hospital with multiple specialties and it receives patients from all over the northern region of Ghana. It is a trauma center and has a large orthopedic and plastic surgery department. The physiotherapy department is a self-standing clinic on the hospital grounds with a busy outpatient gym that treats patients from all spans of life. It is moderately staffed with PTs who provide outpatient and inpatient care. The big rehab gym is equipped with basic therapy equipment. The project was established two years ago by Dr Don Lalonde to develop hand surgery and therapy specialty in KATH. Since its inception, many hand therapy volunteers have travelled to KATH to develop a sustainable hand therapy program. Two KATH therapists are dedicated to UE caseload and train with the volunteers in a one room clinic with a desk, chair and a mat. Supplies and equipment related to hand therapy is scarce and dependent on donations. Knowledge of local therapists in UE anatomy, evaluation and treatment is in its infancy but the enthusiasm of therapists to learn is great. The type of case load varies, mostly complex trauma patients in later stages of healing presenting with severe stiffness, contractures and chronic pain, children with birth defects, brachial plexus and other peripheral nerve injuries. Chronic wound problems and infection are common.

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

The rest of my visit was spent providing direct treatment to hand therapy patients. Robert and the students presented each case and we worked together to identify anatomy, pathology, course of treatment and use of therapeutic activities. I focused on education about pain management, empathy, importance of the home exercise program and orthosis management for chronic stiffness, and had the opportunity to review some patients who came back later in the week for follow up. The week concluded with my presentation on the ‘Evidence based use of modalities in rehabilitation’ which was received well by an audience of over 10 therapists.

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

The only function she had of her hand was slight adduction of her thumb to index. This became a learning/teaching opportunity for me and Robert and the OT students: do we support her desire to cover her hand or do we help the patient and her mom to accept what is? If we widen her 1st web space, would she still be able to complete her lateral pinch motion, or lose what function is left?
Through empathy, talking with Monica’s mom and listening to Monica about her feelings of her hand, we figured out that writing with that hand is what she misses the most. We spent the session trying writing with various adaptations/techniques and gave her homework to write 1 page every day with that hand and follow up with us later in the week. In her follow up, she ran up to us, gave a hug and produced 3 pages of writing. We all were hugging with tears of happiness. We told her that she had a beautiful hand and that it can do many things if she puts her mind to it. We decided that she won’t need anything to cover her hand. The OT students (second group to ever graduate as OTs in Ghana) told me that this was the first time during their clinical rotation where they were able to observe the clinical application of the academic theory they had learnt at University.

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

The program that started 2 years ago to bring hand therapy concepts in KATH hospital is doing well, attracting volunteers throughout the year. There is much to be done in terms of training, equipment and supporting the department to better treat hand therapy patients. It is my intention that I will try to network and help Robert Sowa, the PT that I worked with, to attend conferences and perhaps shadow in a hand therapy clinic for a few weeks here in the US. I am very grateful to IFSHT for awarding me the grant to assist with my trip to Ghana to share my knowledge and skills of hand therapy. Like always, I learned so much and felt privileged to be doing international hand therapy trips. IFSHT is pleased to report that Robert Sowa has recently applied to join IFSHT as a corresponding member.

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

The APTIS DRUJ prosthesis is a semi-constraint implant that allows patients to regain pain free pronation/supination and, most importantly, lifting! For more information, visit us online at aptismedical.com
How long can surgery for the pediatric trigger thumb be delayed?

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

**TIMING OF SURGERY**

Chalise et al. (2013) reported that trying conservative methods to get a higher chance of recovery is reasonable before the elective surgery because the surgery was not urgent and postponing surgery did not interfere with the result. Skov et al. (1990) reported that the risk of residual flexion deformity was no higher following operations conducted in patients who were more than three years old. Han et al. (2010) reported that the surgical treatment with A1 pulley release for over 5 years of age resulted in successful resolution of trigger thumb and satisfactory clinical outcome in all patients.

My current surgical indications for the pediatric trigger thumbs include ‘no improvement of extension lag for more than 5 years of observation’, and ‘locked pediatric trigger thumbs without any improvement of extension lag for more than 3 years of observation’. Because all the patients with pediatric trigger thumb were initially recommended to be waited for a long time in my clinic, patients’ age at the time of surgery should be older than any other clinics. During last 12 years, I had operated 15 thumbs in 15 patients whose average age at the time of surgery was 7 years and 1 month. Nine of them showed no improvement of extension lag for more than 5 years of observation, and six had locked pediatric trigger thumbs without any improvement of extension lag for more than 3 years of observation. Surgical outcome was excellent in all patients without any residual deformity (Table 1). Then, how long can surgery for the pediatric trigger thumb be delayed? The outcome was excellent if the operation for pediatric trigger thumb is done before teenage (Han et al., 2010; Baek and Lee, 2011). If it is performed after teenage, I believe the surgical outcome will be excellent as well.

**References**


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**Table 1**

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Sex</th>
<th>Affected Side</th>
<th>Age at Detection (Year+Month)</th>
<th>Extension Lag at First Visit</th>
<th>Age at Surgery (Year+Month)</th>
<th>Duration of Resolution</th>
<th>Duration of Follow Up (Year+Month)</th>
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<td>(5° to 12°)</td>
<td>(1 to 2.5)</td>
<td>(2+8 to 11+5)</td>
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We all have mentors that we not only respect as surgical teachers, but who also taught us invaluable lessons regarding the treatment of patients. My two most important mentors were Marybeth Ezaki and Peter Carter. I would like to share important “philosophic” lessons they taught me that I use each and every day in practice, as well as, instil in my trainees.

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

Another is “beware of the merry-go-round”. As we all start practice we are filled with wonderment and ideas on “novel” procedures to perform for a specific diagnosis. It is imperative that we review the experiences of those before us, as many times our “novel” procedure has been tried before. In this way we avoid trying to “re-invent the wheel” and instead either modify or add to what has been done before.

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

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

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

In summary, whilst we learn an incredible amount from our teachers/mentors in regards to specific techniques and diagnoses, some of the most important lessons can be learned from their general approach and philosophies. It is imperative that we are able to understand these and incorporate them into our daily practices as it surely will make us better surgeons.
Two years ago, Manus Canada was transformed into the Canadian Society for Surgery of the Hand (CSSH). The second annual meeting will take place in Winnipeg on June 20, 2017 between 5 and 9PM, preceeding the GAM Canada and CSPS meetings. The 2016 CSSH meeting was held in Ottawa. There were 20 registrants, but with over 80 attendees the meeting had to be relocated to a bigger room to provide seating for all of the CSSH enthusiasts! The program included orthopedic and plastic surgeons from across the country giving practical and clinically-driven topics.

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

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

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

Heather Baltzer - University of Toronto
Paul Binhammer - University of Toronto
Don Lalonde - Dalhousie University

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

In addition to the Annual Meeting and journal, the Hand Association offers a webinar series with the aim to provide hand care education on a global scale. The Association has held 3 extremely well attended webinars in 2016, and another two are being planned for 2017. These webinars are FREE to any and all participants. More information is available online at http://handsurgery.org/.

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

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

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

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

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

In 2016, under the presidency of Rupert Eckersley, we held two very successful scientific meetings in London & Cardiff with the latter being attended by over 450 delegates, a record for the BSSH. Prof Grey Giddens is our president for 2017, and once again we return to the Assembly Rooms in the historic Roman city of Bath for our Spring Meeting – April 27-28th & we visit the Scottish capital, Edinburgh for our Autumn meeting in November (9 – 10th).

All are welcome.

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

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

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

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

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

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

AMERICAN SOCIETY FOR SURGERY OF THE HAND

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

International Visiting Professor Program

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

American Foundation for Surgery of the Hand

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

International Visiting Professor Program

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

International Hand Surgery Fellowship

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

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

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

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

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

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

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

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

Roger Nicholson
President SASSH

SWITZERLAND SOCIETY FOR SURGERY OF THE HAND

Hand Surgery & Therapy at the Crossroad between Science and Craftsmanship

2016 was a special year for the Swiss Hand Surgery Society (SGH) – we celebrated our 50th birthday with a congress together with friends of the Belgian Hand Group, our therapists, therapists from Belgium and from The Netherlands. Our President, Michael Papaloizos, hosted this event in his home town Geneva, a city also known for its watch manufacturers.

Getting an inside view of a famous watchmaker, the precise craftsmanship of a complicated clockwork was demonstrated and paralleled to the mandatory precision in hand surgery. While we exchanged science and craftsmanship during the interesting sessions, old and new friendships as well as our anniversary were celebrated with a memorable evening banquet in a very special environment – a velodrome – till late.

Esther Vögelin and Mario Bonaccio

TAIWAN SOCIETY FOR SURGERY OF THE HAND

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

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

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

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

Impressions from the congress and the passing of the medal from the old president - Michael Papaloizos - to the new one - Mario Bonaccio
TURKISH SOCIETY FOR SURGERY OF THE HAND AND UPPER EXTREMITY

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

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

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

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

VENEZUELAN SOCIETY FOR SURGERY OF THE HAND AND UPPER LIMB RECONSTRUCTION

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

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

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

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

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

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- Outcomes Assessment After Hand Burns
  Shepard P. Johnson, Kevin C. Chung
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- International Disease Burden of Hand Burns
  Daniel S. Corlew, K.A. Kelly McQueen
  p130

Hand Surgery Evidence Updates

Do you want to keep up to date with the latest evidence in hand surgery? Then Hand Surgery Evidence Updates are for you...

Hand Surgery Evidence Updates are free monthly e-mails that highlight new systematic reviews and guidelines as they are published.

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https://www.jiscmail.ac.uk/HAND-SURGERY-EVIDENCE-UPDATES

Alternatively, e-mail douglas.grindlay@nottingham.ac.uk to ask to be signed up.

Hand Surgery Evidence Updates are compiled by the Centre for Evidence Based Hand Surgery at the University of Nottingham, with support from the University of Nottingham, Nottingham University Hospitals NHS Trust and the British Society for Surgery of the Hand (BSSH).
UPCOMING EVENTS

COMPREHENSIVE REVIEW

Examine the full spectrum of upper extremity surgery.
July 7-9, 2017 * Chicago, IL

COURSE SESSIONS:
- HAND/WRIST FRACTURES
- HAND/WRIST SOFT TISSUE TRAUMA
- ARTHRITIS
- MICROVASCULAR
- SELECT SOFT TISSUE CONDITIONS
- NERVE
- ELBOW
- NICHE TOPICS
- PEDIATRICS
- TUMORS

Please note that you will receive a link to download the syllabus prior to the course. If you would like to receive a printed syllabus at the course, you must add it to your registration for an additional fee. Following the course, you will receive a link to download a full-screen version of the presentation slides.

REGISTER NOW

Present your abstract at the 2017 APFSSH Conference!
Deadline for abstract submission is on May 31, 2017

PLENARY SPEAKERS

Early Bird Registration
Register now and save $200. Enjoy the limited-time early bird registration rates until July 31, 2017.

<table>
<thead>
<tr>
<th>Early Bird (December 1, 2016 to July 31, 2017)</th>
<th>Regular Registration (August 1, 2017 to October 31, 2017)</th>
<th>Onsite Registration (November 1, 2017 up to Congress)</th>
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<tr>
<td>Surgeons</td>
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<td>USD 650</td>
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</tbody>
</table>

For more information about the 11th APFSSH, you may visit the official website www.handssociety.org and email the congress secretarial at info@handssociety.org

11th APFSSH2017
November 7 - 10, 2017
Radisson Blu Hotel,
Cebu City, Philippines

www.ifssh.info
On behalf of the Organizing Committee we would like to welcome you to the 8th Instructional Course on Reconstructive Tetraplegia Hand Surgery. This three days course reviews the current concepts in the surgical rehabilitation of upper extremities in patients with tetraplegia.

Our aim is to provide you with a reliable toolbox of operations and rehabilitation protocols that can be applied in the majority of reconstructions necessary in tetraplegia hand surgery. Therefore, a full day will be spent on practicing surgical procedures in cadavers for surgeons and assessment practice, rehab tips and splint fabrication for therapists. By the end of the day surgeons will demonstrate for therapists the procedures undertaken.

Congress Date: 26-29 September 2017
Congress Venue: Hotel Andrassy Residence
H-3915 Tarcal, Hungary
F6 u. 94.

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

Registration deadline: 1 June 2017

Registration fees:
Therapists fee: 650 EUR
Surgeons fee: 950 EUR

For more information and registration please visit the congress website

Best wishes,
ASSZISZTENCIA Congress Bureau
Congress Secretariat
H-1055 Budapest, Hungary
Szent Istvan krt. 7
Phone: +36 1 350-1854
Fax: +36 1 350-0929
E-mail: tetraplegia@asszisztencia.hu
Web: www.asszisztencia.hu/tetraplegia/2017
UPCOMING EVENTS

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

2017
Viernes 09 Junio

43º Curso de Actualización en Cirugía de la Mano y Miembro Superior
“Cuando lo simple se complica”

Presidente AACC
Dr. Leandro Argañaraz
Secretario General
Christian Perrotto
Secretario Científico
Guillermo Mayo

Centro Cultural Parque de España
ROSARIO SANTA FE
Inscripción ONLINE
Cierre: 25/5

VEMES EVENTS

VENUES

3rd Brachial Plexus Cadaveric Dissection Course 2018
The 3rd Brachial Plexus Cadaveric Dissection Course 2018

PROGRAM

Tuesday 13th March, 2018

6:00-8:15 Opening Ceremony
6:10-8:30 Anatomy of Brachial Plexus
6:20-8:30 Patho-physiology of Adult Brachial Plexus Injury
6:30-8:40 Role of Nerve Grafting in Adult Brachial Plexus
6:40-8:50 Shoulder Biomechanics
7:00-9:30 Brachial Plexus: Suprascapular Nerve Transfer
7:20-9:30 Interosseous Nerve Transfer to Supraspinatus Nerve
7:30-9:30 Shoulder Arthroscopy
7:40-9:30 Tendon Transfer for Shoulder Function
8:00-9:30 Sensory Arterial Dysplasia and Management
8:20-9:30 Thoracodorsal Nerve Transfer to Long Thoracic Nerve

9:00-10:30 Break
10:30-10:50 Nerve Transfer for Digital Reinnervation
10:40-10:50 Nerve Transfer for Shoulder Function
10:40-10:50 Outcomes Method: 25 Years Experience
11:00-10:50 Nerve Transfer for Elbow Flexion
11:00-10:50 Free Functional Muscle Transfer in BPI
11:00-10:50 Direct Cuff Nerve Transfer (C7 Transected)
11:00-10:50 Direct Cuff Nerve Transfer (C5 Transected)
11:00-10:50 FTMT for Chronic Total Arm Type BPI
12:00-10:50 Reparative Hand in BPI
12:00-10:50 Discussion 1
12:30-10:50 Nerve Transfer in C8 Palsy
13:30-10:50 Natural History and Clinical Evolution of OBPI
13:40-10:50 Study of OBPI Treatment
13:50-10:50 Pathology between OBPI and C8 Palsy
14:00-10:50 How to Manage Shoulder Problem in OBPI
14:10-10:50 Free Nerve Transfer in Tamperey Patient
14:20-10:50 Management of Pain in Brachial Plexus Injury
14:30-10:50 Design of Innovation in Upper Limb Muscles
14:30-10:50 Discussion 2
16:10-15:20 Break
16:30-10:50 Case Discussion

INTERNATIONAL SPEAKERS

1. Suprascapular nerve transfer
2. Introductory approach
3. Medial arm approach concludes (O’keeffe’s transfer)
4. Interosseous nerve dissection
5. Pectoral nerve dissection
6. Free functional muscle transfer
7. Nerve to long head tendon to anterior nerve
8. Thoracodorsal nerve to long thoracic nerve
9. Contralateral C7 nerve transfer
10. Spinal accessory nerve to suprascapular nerve
11. Dorsal cutaneous nerve transfer for wrist and finger extension

WEDNESDAY 14TH MARCH, 2018 Cufflink Workshop

Vlamas Workshop

www.ifssh.info
Cher Ami. L’année 2017 étant laquelle l’auteur eu l’honneur et la fierté de présider la SFOM, se terminera par notre congrès annuel. Du fait de la proximité des Fêtes de Noël, les dates traditionnelles du congrès ont été fixées du lundi 18 décembre à 14h au mercredi 20 décembre 18h00. Cela facilitera votre participation qui nous l’espérons sera toujours plus nombreuse. Le programme du congrès sera, je le pense, aussi riche que passionnant. Vous pouvez y contribuer activement par une communication orale, un e-poster ou un vidéo-talk en soumettant votre abstract entre le 15 avril et le 15 juin.

Les conférences d’ouverture auront pour sujet le traitement des pénuries de substances pulvérisées et de la face palmaire des doigts, des raideurs digitales, des pseudofractures du scaphoïde, des transferts sériatiques, vasculaires à la main, de la biologie du développement embryonnaire de la main enfin des lésions en gyracorde à la main et au poignet. Notez que cette dernière conférence permettra de cloturer votre DPC 2017 que je vous invite à valider avec le SFOM directement sur son site (voir ci-dessus) avant le 30 avril prochain.

La Suisse sera notre invité d’honneur. Une délégation, constituée d’Ester Vögeli, Maurizio Caligiuri, Daniel Herren, Ladis Napo, Michael Papaditz et Stephan Schmitz, participera avec nous aux salles de réunification et de débat et contrewill leurs expériences souvent originales. Aymer, un autre invité étranger de Suisse, nous exposera l’univers des transferts neurovasculaires.

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

Philippe Bellettre
Président de la SFOM 2017

SOCIÉTÉ FRANÇAISE DE CHIRURGIE DE LA MAIN
THE FRENCH SOCIETY FOR SURGERY OF THE HAND
SFOM 2017

SAVE THE DATES

16 AVRIL
JOURNEE D’OCCASION
Ouverture de la plateforme de soumission d’abstracts
Opening of abstracts submission platform

15 JUIN
JOURNEE D’OCCASION
Clôture de la soumission d’abstracts
Closing of submission platform

2 NOVEMBRE
NOVEMBRE 2017
Fin du call préférentiel
End of early registration

60 61

• 8 simultaneous workshops
  Tendon Repair
  Flaps in the Hand
  Anchors in Hand & Wrist
  SWE & Splaihead Fixation
  MC & Phalanges Fixation
  ECTR & 1st CMC joint
  EMG NC demonstration
  Splint Making
• Breakfast Sessions
  5 simultaneous sessions each day
• Orations, Symposia, PanelDiscussions, Keynote Talks, & more

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Master Class,
Symposia & more!

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98195 30321

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Email: vamahospitality@hotmail.com
Website: www.vamaitaevents.com
Phone: +91 22 2248 3498
Call for Abstracts

The Asia Pacific Wrist Association (APWA) invite you to submit abstracts for the
APWA 3rd Annual Congress - 6-8 October 2017 - Adelaide, Australia.

It promises to be an exciting meeting with a strong international scientific program.
The Asia Pacific Wrist Association is a non-profit international scientific association open to all individuals involved or interested in disorders of the wrist and its surgical and non-operative management.

APWA 2017 is aimed at hand surgeons, trainees, students and hand therapists.
The conference will be at the “state of the art” Flinders Advanced Surgical Training facility at Tonsley Campus of Flinders University. Cadaveric demonstrations will be beamed from the Cadaveric Lab to the Lecture Theatre. This will enable the attendees to witness the quality faculty demonstrate principles of anatomy, examination and surgery. Lectures and panel discussions will follow.

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

Yours sincerely

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

Faculty
International
Alejandro Badia (USA)
Tyson Cobb (USA)
Marc Garcia Elias (Spain)
Diego Fernandez (Switzerland)
Max Haesl (Germany)
Philippe Lvernaux (France)
Steve Moran (USA)
Nash Naam (USA)
Jorge Orbay (USA)

Hand Therapy
Jay McDermid (Canada)
Josephine Wong OT (Hong Kong)
Polina Young PT (Hong Kong)

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

Program Outline
Approximate times - subject to change.
Thursday 5th October 2017
1900-2230 Faculty Reception
Friday 6th October 2017
0800-1600 Cadaveric Workshop
Saturday 7th October 2017
0800-1600 Academic program and exhibition
1900-2300 Congress Dinner, Adelaide Oval
Sunday 8th October 2017
0800-1600 Academic program and exhibition
Dedicated Hand Therapy sessions

Sponsors

Submit Abstracts to APWA Website
http://apwa.asia
Follow submission guidelines

Submissions close:
Mon 12th June 2017

Congress Secretariat
The Meeting People Pty Ltd
PO Box 794, MTTCHAM South Australia 5622
Tel: +61 8 8177 2215
lara@themeetingpeople.com.au

Fax: www.ifssh.info
Save the Date
20–24 May 2019

Building Bridges – Together Hand in Hand

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