S.A. Society for Surgery of the Hand

S.A. Vereniging vir Handchirurgie

CONGRESS 1991 KONGRES

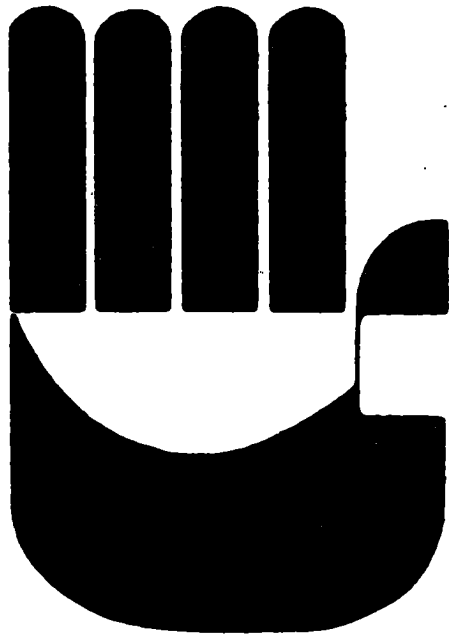
Venue: Johannesburg Hospital

* Article: Lunatomalacia
Stendler / Lat-dori

*

THE SOUTH AFRICAN SOCIETY FOR SURGERY OF THE HAND

22nd CONGRESS
JOHANNESBURG



31 AUGUST - 1 SEPTEMBER 1991

22ste KONGRES

DIE SUID-AFRIKAANSE VERENIGING VIR HANDCHIRURGIE

CONTENTS
INHOUDSOPGAWE

MESSAGE OF WELCOME

DR SYD L BIDDULPH
PRESIDENT
of
THE SOUTH AFRICAN SOCIETY FOR SURGERY OF THE HAND
and
CONGRESS CHAIRMAN
1991

Although I was not a founder member of the 1970 SASSH, I am privileged to have been associated with the society since 1990. As the society enters its third decade of existence, many of its original objectives have been attained. Membership has more than quadrupled. The annual congress has become a significant feature in the medical calendar. Over the last few years it has been complemented by a very rewarding Instructional Course.

In the past we have been honoured by the presence of Giants in the art of hand surgery and 1991 proves to be no exception.

We are delighted that Professor Ivan Matev from Bulgaria accepted our invitation for 1991. The eminence he has reached in the Western hemisphere is testimony to his integrity and achievements. He has written numerous papers and has a wide knowledge of hand surgery. This will make him particularly valuable in the Instructional Course.

We have arranged a varied programme which we trust you will find interesting and thought provoking. It is the congress committee's sincere wish that you will enjoy it.

IVAN B MATEV M D , D Sc

PROFESSOR OF ORTHOPAEDIC SURGERY
INSTITUTE OF ORTHOPAEDICS AND TRAUMATOLOGY SOFIA, BULGARIA

INTERNATIONAL GUEST LECTURER
at the
ANNUAL CONGRESS AND INSTRUCTIONAL COURSE
of
THE SOUTH AFRICAN SOCIETY FOR SURGERY OF THE HAND

31 AUGUST - 1 SEPTEMBER 1991
JOHANNESBURG

PAST PRESIDENTS
VORIGE PRESIDENTE

1970 - 1971	*I KAPLAN*
1971 - 1973	*A C BOONZAIER*
1973 - 1975	*M SINGER*
1975 - 1977	*J H YOUNGLESON*
1977 - 1979	*T L SARKIN*
1979 - 1981	*C E BLOCH*
1981 - 1983	*S L BIDDULPH*
1983 - 1985	*W M M MORRIS*
1985 - 1987	*L K PRETORIUS*
1987 - 1989	*K S NAIDOO*

OFFICE BEARERS
AMPSDRAERS

PRESIDENT	*S L BIDDULPH*
HONORARY SECRETARY/ TREASURER ERE-SEKRETARIS/ TESOURIER PRESIDENT-ELECT	*B J VAN R ZEEMAN*
MEMBERS/LEDE	*R BOOME* *U MENNEN* *K S NAIDOO* *L K PRETORIUS*
EXECUTIVE SECRETARY/ UITVOERENDE SEKRETARESSE	*HENDRIKA VAN DER MERWE*

CONGRESS COMMITTEE KONGRES KOMMITTEE 1991	*S L BIDDULPH* *D MACKAY* *J FLEMING*

ANNUAL GENERAL MEETING
ALGEMENE JAARVERGADERING

31 AUGUST 1991

1620 - 1730

(members only/lede alleenlik)

Venue/Plek: Johannesburg Hospital

1
Welcome address by the President
Verwelkoming deur die President

2
Apologies & Proxies
Verskonings & Volmagte

3
Minutes of the previous Annual General Meeting
Notule van die vorige Algemene Jaarvergadering

4
Matters arising from the minutes
Sake wat uit die notule voortspruit

5
President's report
President se verslag

6
Honorary Secretary /Treasurer's report
Ere-Sekretaris/Tesourier se verslag

7
Announcement of new Executive Committee members for the period September 1991 - September 1993
Aankondiging van nuwe Uitvoerende Bestuurslede vir die tydperk September 1991 - September 1993

8
Announcement of new members
Aankondiging van nuwe lede

9
General
Algemeen

10
Next Annual General Meeting
Volgende Algemene Jaarvergadering

SOCIAL EVENTS
SOSIALE BYEENKOMSTE

31 AUGUST 1991

1930 for/vir 2000

BANQUET/BANKET

(delegates and partners/
kongresgangers en metgeselle)

SUNNYSIDE PARK HOTEL
PARKTOWN
JOHANNESBURG

1 SEPTEMBER 1991

1750
COCKTAIL PARTY

(delegates and partners/
kongresgangers en metgeselle)

EMOYENI
WITS MEDICAL SCHOOL

LADIES PROGRAMME
DAMESPROGRAM

Saturday 31 August *0930 - 1300*	*Visit to Bryanston Organic Village Market*
Sunday 1 September *1030 - 1430*	*Visit to Johannesburg Art Gallery-Lunch*

Transport will leave from the Sunnyside Park Hotel at 0930 on Saturday and 1030 on Sunday.

CONGRESS
KONGRES

SATURDAY 31 AUGUST 1991

0730 - 0800	*Registration/Registrasie* *Medical School* *University of the Witwatersrand* *JOHANNESBURG*
0800 - 0810	*Welcome and announcements* *Verwelkoming en aankondigings*
0810 - 1000	*Scientific presentations* *Wetenskaplike voordragte*
1000 - 1030	*Tea/Tee*
1030 - 1300	*Scientific presentations* *Wetenskaplike voordragte*
1300 - 1400	*Lunch/Middagete*
1400 - 1415	*Presidential Report* *Verslag van die President*
1415 - 1600	*Scientific presentations* *Wetenskaplike voordragte*
1600 - 1605	*Closure of the Congress by the President* *Afsluiting van Kongres deur die President*
1605 - 1620	*Tea/Tee*
1620 - 1730	*Annual General Meeting (members only)* *Algemene Jaarvergadering (slegs lede)*
1930	*Banquet (delegates and partners)* *Banket (kongresgangers en metgeselle)* *Sunnyside Park Hotel, Parktown, Johannesburg*

THE SOUTH AFRICAN SOCIETY FOR SURGERY OF THE HAND CONGRESS
DIE SUID-AFRIKAANSE VERENIGING VIR HANDCHIRURGIE KONGRES
JOHANNESBURG

31 AUGUST 1991

0730 - 0800 *Registration/Registrasie*
Main Auditorium
Johannesburg Hospital
JOHANNESBURG

0800 - 0810 *Welcome and announcements* *DR S L BIDDULPH*
Verwelkoming en aankondigings

CHAIRMAN/VOORSITTER: DR S L BIDDULPH

0810 - 0840 ***LUNATO-MALACIA***
PROF IVAN B MATEV (Sofia, Bulgaria)

0840 - 0845 *Discussion/Bespreking*

0845 - 0855 ***PLASTER CAST vs CLYBURN EXTERNAL FIXATOR FOR FRACTURES OF THE DISTAL RADIUS IN PATIENTS UNDER 45 YEARS OF AGE***
DR E C R MERCHAN (Madrid, Spain)

This study describes a retrospective review comparing closed reduction and plaster case immobilization (historical group, 48 cases) with an external fixator (dynamic Clyburn, 35 cases) in patients between 20 - 45 years of age presenting with displaced distal radial fractures. Nearly all fractures treated with external fixation remained well reduced and aligned, whereas more than 80 % of those treated with casts had unsatisfactory alignment despite the fact that 50 % had a second reduction. The external fixator group also had superior functional results, although 20 % of patients experienced minor problems with the pin sites. This study demonstrated the advantage of using a dynamic external fixator to treat reduced distal radial fractures over closed reduction and plaster cast immobilization in patients under 45 years of age.

0855 - 0900 *Discussion*

0900 - 0910 ***DYNAMIC SPLINTS - A SOLUTION TO THE FRICTION PROBLEM?***
MS C VAN VELZE (Medunsa)

In a previous study it was determined that the amount of force exerted on a finger by a dynamic splint, is dependent on two factors, namely the consistency and reliability of the rubber band, which is used as a power source, and the amount of friction over the outrigger. This study was designed to compare the amount of friction caused to different outrigger systems with each other. Two different outrigger systems, namely a brass

Kienböck 1910 (1871 – 1953)
Peste 1843.

NOTES

Hulten 1928.
78% ulna neg. variance.
23% " norm.

Porier 1927
— triangular lig. varies in thickness depending on length of ulna in order to equalize the length.
Two forearm bones vary in length depending on pro- and supin.

No L-M after Darach
Abnormal formed joint — ?!
Lichman modif.

1 transv. # line
2. density changes
3 colapse
4 pan carpal OA

Rx = Denervation
= Vascular changes due to ф + inflam
— Post-op immobil.
(* ? other AV. conditions — surely same path ?!)

welding rod and a stainless steel rod were attached to two different splint bases. One of each outrigger system was coated with a layer of Teflon paint and the other one was left uncovered. Four different traction units, consisting of a 5mm tension spring and a fishing line loop were attached to the splints. Thereafter 300g was hung on each loop and the lengthening of the spring was measured and recorded. The above sequence was repeated 80 times for each outrigger system, using a total of eight different tension springs. The results indicate that a stainless steel outrigger covered with Teflon paint caused the least amount of friction. The practical implications of the above findings for the splintmaker will be presented and discussed.

0910 - 0915 *Discussion/Bespreking*

0915 - 0925 ***BONE SCINTIGRAPHY IN THE ASSESSMENT OF SCAPHOID FRACTURES***
DR B VRETTOS (Cape Town)

The early diagnosis of carpal scaphoid fractures is important to prevent the complications of pseudoarthrosis and avascular necrosis that often follow a delay in immobilization. The prompt confirmation of the absence of a fracture in a patient presenting with snuffbox tenderness following a wrist injury will preclude the inconvenience of unnecessary immobilization. On initial radiographs, it may be impossible to identify the patient with a fracture. Bone scintigraphy has been shown in a number of studies to be a sensitive method of detecting the presence of scaphoid fractures. A prospective study of 50 patients with clinically suspected scaphoid fractures was performed. At presentation all had an initial clinical assessment and a radiograph. A further clinical assessment and radiograph were performed two weeks later. All patients had the scintigraphy on average at 67 hours post-injury. The results of clinical assessments and radiographs were compared with the scintigraphic findings. Bone scintigraphy was found to be an extremely sensitive (100 %) modality for confirming the presence of clinically suspected scaphoid fractures. The bone scintigraphy proved capable of identifying those patients who had not sustained fractures and who therefore did not require plaster immobilization. In 14 (28 %) of the cases the bone scintigraphy identified fractures in other bones in and around the carpus which had not been seen on the initial or later radiographs.

0925 - 0930 *Discussion/Bespreking*

0930 - 0940 ***THE EFFECT OF POSTOPERATIVE BLEEDING ON INTRA-COMPARTMENTAL PRESSURE: IS TOURNIQUET RELEASE AND HAEMOSTASIS NECESSARY BEFORE WOUND CLOSURE?***
DR M MARS (Durban)

It is still common practice when operating in bloodless field to close the wound, apply a compression bandage and then deflate the tourniquet. Both compression bandaging and tourniquet release are known to raise limb intracompartmental pressure (ICP). The added effects of surgical trauma and post operative haemorrhage on ICP in this situation are not known. The aims

NOTES

of this study were (i) to determine if surgical trauma and post-operative haemorrhage cause a prolonged rise in ICP, and (ii) to determine the effect on ICP of releasing the tourniquet and gaining haemostasis prior to wound closure and compression bandaging. Eight adult chacma baboons were studied under general anaesthesia. A forelimb was exsanguinated using an Esmarch bandage and a pneumatic tourniquet was applied at 100mmHg above systolic pressure for 90 minutes. A standardised sham operation exposing the mid third of the radius was performed on a forelimb. In group 1 (n = 4), the wound was closed without fascial repair, a slit catheter inserted into the forearm flexor compartment to measure the ICP and a compression bandage applied at a bandage pressure of 20 - 30mmHg before tourniquet release. In group 2 (n = 4), the tourniquet was deflated after 90 minutes, haemostatis gained, the wound closed and a compression bandage applied at 20 - 30mm Hg. In both groups bandage pressure and ICP were monitored for three hours. Bandaging caused a corresponding rise in ICP and changes in bandage pressure and ICP showed a significant correlation r = 0.93 p 0.001 (n = 200). In group 1 tourniquet release was associated with a further increase in ICP lasting up to 2.5 hours. The highest ICP measured was 41mmHg. In group 2 the increase of ICP was related only to the bandage pressure and fell during the observation period. After three hours reperfusion ICP's of the two groups were significantly different p = 0,035. The conclusions made were (i) tourniquet release following limb bandaging causes a prolonged increase in ICP and (ii) deflating the tourniquet and gaining haemostasis will reduce the risk of a prolonged increase in ICP and also reduces the need to apply a compression bandage.

0940 - 0945 *Discussion/Bespreking*

0945 - 0955 ***PHALANGEAL FRACTURES: THE CAPE TOWN EXPERIENCE***
DR T DE CHALAIN (Cape Town)

This study was begun as a self-evaluation exercise, aimed at establishing the success or otherwise of phalangeal fracture management in a Hand Surgery referral Unit at a major teaching hospital attached to the University of Cape Town. The patient population is primarily semi-skilled and unskilled labour, unsophisticated and often from appalling social circumstances. It is these factors which make these common injuries both so rewarding and so frustrating to treat: On the one hand the patient is generally well motivated and eager to return to work. On the other hand, his lack of sophistication makes it difficult for him to appreciate the aims of therapy and the rate of absenteeism from follow-up visits is extremely high. Accordingly, the (would-be first world) therapy must often be tailored to fit the (non-medical, third world) needs of such patients. In total 174 fractures of the proximal and middle phalanges of the fingers and thumbs in 154 patients were seen in this Unit over a 12 month period. These fractures are analised in terms of mechanism, type, demography, treatment and complications in the short- and long term. Contrasts between this data and that pertaining to first world studies are discussed.

0955 - 1000 *Discussion/Bespreking*

1000 - 1030 *TEA/TEE*

NOTES

CHAIRMAN/VOORSITTER: PROF K S NAIDOO

1030 - 1055 **THE LONG GRAFT FOR FLEXOR TENDON REPAIR**
PROF IVAN B MATEV (Sofia, Bulgaria)

1055 - 1100 *Discussion/Bespreking*

1100 - 1110 **THE RESULTS OF FLEXOR TENOLYSIS IN CHILDREN**
DR R H BIRNIE, DR R IDLER (Tygerberg)

The indications for tenolysis following flexor tendon surgery are well established. These are: (1) A highly motivated patient (2) Maximum passive flexion of the involved digit(s) and (3) Quiescent, supple soft tissue. According to the literature, one can expect 80 % of adult patients to be improved by tenolysis. But what of children? If co-operation and motivation is so important in obtaining a good result, is there not an age below which it may be pointless attempting this? No consensus exists and various authorities have suggested that this procedure may be performed in children as young as 4 years old. A retrospective study was undertaken at the Indiana Center for Surgery and Rehabilitation of the Hand and Upper Extremity of all children 16 years and younger treated from 1972 - 1989 with sharp soft tissue injuries involving the flexor tendons in Zone II and III. There were 26 patients with injuries to 29 digits. Length of follow-up averaged 1,9 years. The average duration between repair and tenolysis was 19 months. The method of evaluation used was that devised by Whitaker & Strickland. (The Role of Flexor Tenolysis in the Palm and Digits. JHS 2: 462-470, 1977). The formula determines the percent of pre-operative passive motion in excess of the active motion achieved following tenolysis. There were 62 % excellent and good results in the 11 - 16 year age group and none in the 10 years and young group. In this study it is clearly evident that flexor tenolysis should not be performed in children under 10 years old as results are more than likely to be poor.

1110 - 1115 *Discussion/Bespreking*

1115 - 1125 **SIMULTANEOUS LACERATION OF THE MEDIAN AND ULNAR NERVES WITH FLEXOR TENDONS AT THE WRIST**
DR D A HUDSON (Cape Town)

The results of a retrospective study of the repair of 24 simultaneous lacerations of the median and ulnar nerves with flexor tendons at the wrist are presented. Most of the injuries were due to knife wounds in manual labourers. Although most of the patients have adequate recovery for the activities of daily living, many are unable to return to manual work. The follow-up period varied between one and five years.

1125 - 1130 *Discussion/Bespreking*

NOTES

1130 - 1140 ***RADIAL NERVE PALSY***
DR L T DE JAGER, DR I SANPERA, DR M SINGER (Cape Town)

The results of 95 radial nerve palsies are presented. Closed injuries causing neuropraxia and/or axonotmesis may recover surprisingly slowly. In neurotmesis, recovery after nerve repair takes much longer than after tendon transfer, but the quality of the end result is better. Rehabiliation after tendon transfer is more intensive than after nerve repair. Therefore, even in countries with limited resources, it is still worthwhile to do a nerve repair rather than an early tendon transfer. Internal splintage by early limited tendon transfer is to be avoided, because, inter alia, wrist flexion is permanently limited. Iatrogenic radial nerve palsies are discussed in detail.

1140 - 1145 *Discussion/Bespreking*

1145 - 1155 ***THE REHABILITATION OF SEVEN BRACHIAL PLEXUS LESION CASES FOLLOWING LATTISIMUS DORSI TENDON TRANSFER AND STEINDLERS FLEXOPLASTY TO MOTORIZE THE ELBOW***
MRS I M EGGERS, DR A MATIME (Medunsa)

Seven adult patients with traumatic brachial plexus lesions following a Lattisimus dorsi tendon transfer into biceps (3) and four cases of Steindlers flexoplasties to motorize the elbow will be presented. An intensive hand therapy programme was given to these patients before and after surgery. All cases were upper trunk or lateral cord injuries except one (who had a posterior cord and musculocutaneous nerve involvement). The three cases of Lattisimus dorsi transfer and the four cases of Steindler flexoplasty will be analised showing severity of lesion (motor and sensory involvement), time at which the surgery was undertaken, strength of donor muscles, whether the dominant or non-dominant side was affected and if additional surgical procedures had to be undertaken. The rehabilitation in occupational therapy will show: (a) the recording of manual muscle tests over a period of at least 2 years of follow-up; (b) dominance retaining where necessary; (c) the flail arm sling and wrist extension splint given where necessary; (d) pre-operative intensive training of donor muscles to maximal resistance capacity; (e) the awareness training of the new function of the donor muscle "AHA"; (f) contact with employer; (g) home programme after "AHA"; (h) additional operations required to gain function; (i)vocational rehabilitation where necessary; (j) a video on the regaining of "function". "The criteria of success" will be discussed from "the function within the work area" point of view.

1155 - 1200 *Discussion/Bespreking*

NOTES

1200 - 1210 ***THE DIAGNOSIS AND MANAGEMENT OF ULNAR NERVE ENTRAPMENT AT THE ELBOW***
DR R S BOOME (Cape Town)

Over the period 1985 to 1990 the diagnosis and management of 130 patients with ulnar nerve entrapment at the elbow have been reviewed. Virtually all patients had no previous injury but presented with varying degrees of ulnar nerve functional loss. The commonest presenting complaint is pain rather than numbness in the fingers and this pain is diffuse, extending from the elbow to the wrist and hand. This diagnosis is commonly missed at the first consultation by the patient's doctor and therefore tends to be diagnosed late. The management is one of local release at the elbow, with or without neurolysis. Anterior transposition of the ulnar nerve is reserved for those patients with a subluxing ulnar nerve or failed local release. The diagnosis, operative management and results will be presented and discussed.

1210 - 1215 *Discussion/Bespreking*

1215 - 1225 ***BENIGN GIANT CELL TUMOUR OF SYNOVIUM***
DR S L BIDDULPH (Johannesburg)

A personal series of 44 cases seen over a 10 year period is reported. The terminology, aetiology, pathology and treatment are discussed. 75 % of tumours were found on the flexor aspect of the hand and 80 % occurred on the radial half of the hand. Most cases were seen in the third to sixth decade and there was a 3 : 1 female to male distribution. No cases of malignant change have been recorded. Recurrence rate after simple excision varies from 4 % to 35 %.

1225 - 1230 *Discussion/Bespreking*

1230 - 1240 ***FUNCTIONAL COMPARISON OF BILATERAL RECONSTRUCTION OF UPPER LIMB IN A TETRAPLEGIC PATIENT***
DR J U KUEBLER, DR W KUHN (Johannesburg)

Surgical reconstruction of upper limbs in tetraplegic patients are leading them to much more independence. In bilateral reconstruction the goal is to give different types of function to each hand. A case is presented in which different procedures were used in each limb which pre-operatively showed the same function deficit. The different procedures are shown and the functional results in comparison were noticed. In the one limb where an arthrodesis of the CMC joint of the thumb was performed, the patient had more power grip but less ability to open the first web space. On the other hand where dynamic control of the thumb was achieved he got less power but more ability to open the first web space.

1240 - 1245 *Discussion/Bespreking*

NOTES

1245 - 1255 ***THE INCIDENCE OF DUPUYTREN'S DISEASE IN DIABETICS***
DR R NACHEF, DR S L BIDDULPH, DR E SCHNAID (Johannesburg)

This study is based on the examination of 200 white diabetic patients (200 male and 100 females) aged between 40 and 60 years. An attempt is made to establish the incidence and localisation of Dupuytren's disease in this group according to: (a) age; (b) sex; (c)type, duration and treatment of diabetes mellitus. The results are compared with a control group of 200 non-diabetics of the same age and sex.

1255 - 1300 *Discussion/Bespreking*

1300 - 1400 *LUNCH / MIDDAGETE*

1400 - 1415 ***PRESIDENTIAL REPORT***
DR S L BIDDULPH

CHAIRMAN/VOORSITTER: DR L K PRETORIUS

1415 - 1425 ***FACTORS RESPONSIBLE FOR BURNS OF THE FOREARM FOLLOWING PLASTER OF PARIS VOLAR SPLINT APPLICATION***
DR F C PEART (Johannesburg)

Burns of the forearm as a complication of volar Plaster of Paris splints have been known to occur. These were due to the high temperatures generated by the casting material during its exothermic setting. Contributing factors to the curing temperature have been identified in the literature as being (i) the type of plaster (in this study only Gypsona was used); (ii) the temperature of the dipping water; (iii) the presence of insulating materials; and (iv) the amount of water saturating the plaster at the time of application. The aim of this study was to ascertain how these factors influence the peak curing temperature of Gypsona. By means of thermocouples fixed to the forearms of human volunteers beneath such volar splints, with the above factors varied, the peak skin-plaster interface temperature and its duration was measured. These data were correlated with human temperature - injury curves obtained from previous experimentation as documented in the literature. Specific guidelines for safe Gypsona volar splint application have been generated and will be presented.

1425 - 1430 *Discussion/Bespreking*

1430 - 1440 ***THE REGENERATIVE CAPACITY OF THE TRAUMATIZED DORSAL ROOF OF THE NAILFOLD***
DR J J VAN WINGERDEN (Pretoria)

As near-as-normal nailfold consisting of a dorsal roof and ventral floor is essential, not only from an aesthetic point of view, but also in directing the growing nail distally and horizontally (Kligman's Vector Force). Whereas post-burn nailfold injuries require active surgical reconstruction, it is our intention to demonstrate that this is not always necessary to mechanically traumatized (or excised) nailfold injuries.

1440 - 1445 *Discussion/Bespreking*

NOTES

1445 - 1455 ***CONGENITAL SWAN NECK DEFORMITY - FACT OR FALLACY***
DR M VAN ROOYEN, DR JJ VAN WINGERDEN, DR M DE GRAAD (Pretoria)

The dirth of literature on the occurrence and management of the swan neck deformity in children probably reflects the rareness of the condition and, or the good prognosis by conservative management, alone. The aim of this paper is to demonstrate the existence of this condition in children, to re-assess possible causes and to discuss the most appropriate forms of management, both conservative and surgically.

1455 - 1500 *Discussion/Bespreking*

1500 - 1510 ***FREE PLANTARIS (OR ACHILLES) OSSEO-TENDINOUS TRANSFER TO RECONSTRUCT FINGER FLEXION***
PROF U MENNEN (Medunsa)

A new method to restore flexion of fingers is described whereby the plantaris tendon (or part of the tendo achilles) with its bony insertion is transferred to the finger. Strong bony anchorage is achieved in the distal phalanx, while a sound interweaving suture technique proximally in the palm will ensure enough strength to allow immediate mobilization.

1510 - 1515 *Discussion/Bespreking*

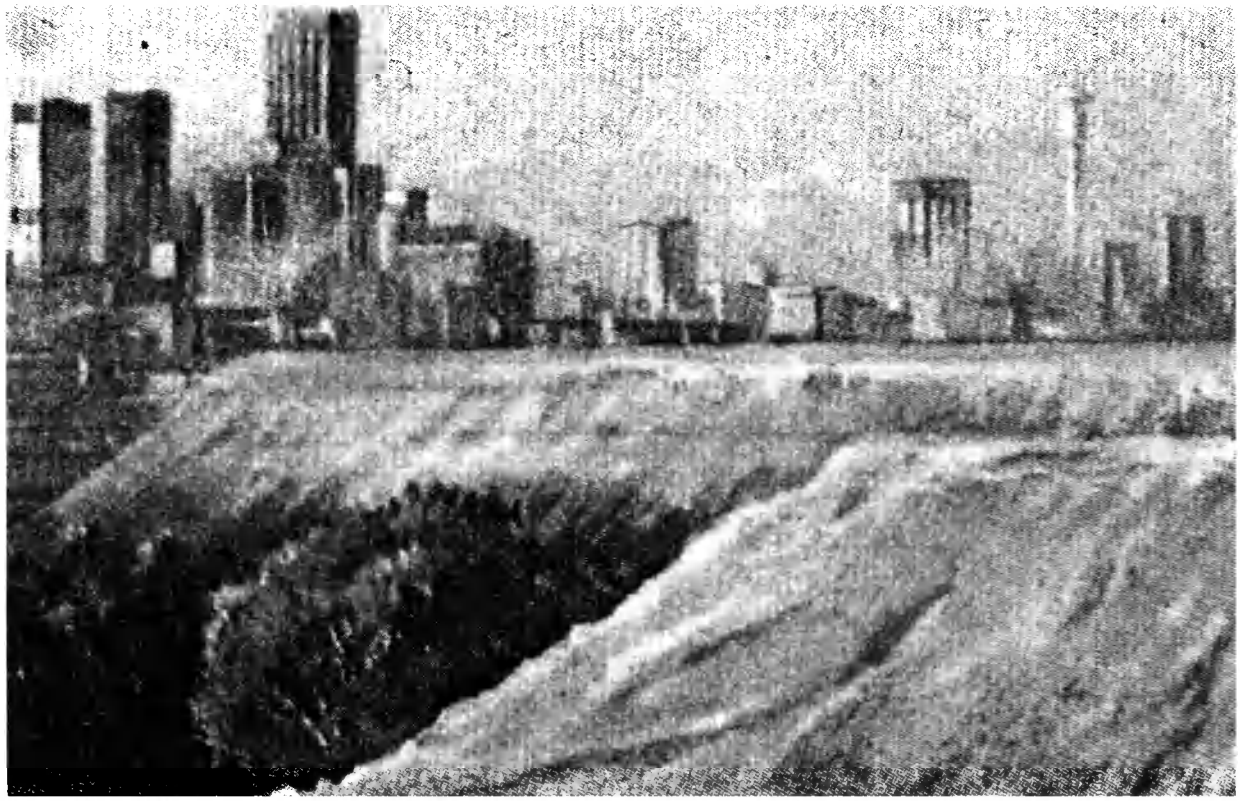
1515 - 1525 ***MANAGEMENT OF FINGERTIP INJURIES WITH SEMI-OCCLUSIVE DRESSING ("OPSITE")***
PROF U MENNEN, MS A WIESE (Medunsa)

Fingertip injuries have been treated by a wide variety of methods. It is presently accepted that skin and soft tissue loss of fingertips, especially in children, may well be treated by regular dressing only. Recent reports have even shown this method to be quite sufficient in adults. The cosmetic appearance and the sensibility of the fingertip usually turns out superior to surgical forms of management. Apart from the obvious advantages of regular dressings only, e g low cost, no surgery, some annoying drawbacks may make this form of treatment not suitable for some patients. It is for this reason that we have developed an even more simple, cheaper and more efficient form of management using a semi-occlusive dressing ("Opsite"/Smith & Nephew). The fingertip is covered with the Opsite once a week only. The dressing renders the finger with a "skin", making it painless. This semi-occlusive "skin" allows the healing environment to reach an optimal milieu (e g pH, oxygen tension, immuno-agents) actively promoting granulation tissue formation and epithelization. The dressing should not be changed more than once a week. If this is ignored, disturbance of a normal healing process if effected. The result of two hundred fingertip injuries treated with this method proves the development of a near normal pulp shape and useful epithelium. Healing occurred on average within twenty days after only three to four dressings, depending on a number of factors which will be discussed. This management method is strongly recommended as the treatment of choice for all types of fingertip injuries.

1525 - 1530 *Discussion/Bespreking*

NOTES

1530 - 1555	***ESSENTIALS IN THUMB RECONSTRUCTION BY BONE LENGTHENING*** *PROF IVAN B MATEV (Sofia, Bulgaria)*
1555 - 1600	*Discussion/Bespreking*
1600 - 1605	*Closure of Congress/Afsluiting van Kongres* *DR S L BIDDULPH*
1605 - 1620	*TEA/TEE*
1620 - 1730	*Annual General Meeting (members only)* *Algemene Jaarvergadering (slegs lede)* *(Venue/Plek: Auditorium)*
1930	*Banquet (delegates and partners)* *Banket (kongresgangers en metgeselle)* *(Venue/Plek: Sunnyside Park Hotel)*



1 Examination

2 Sensation vs Sweat

3. Opponens palsy

4 Motor loss – med N. –

NOTES

"Opponens syndrom"

M. oppon: abduct, pronate } function

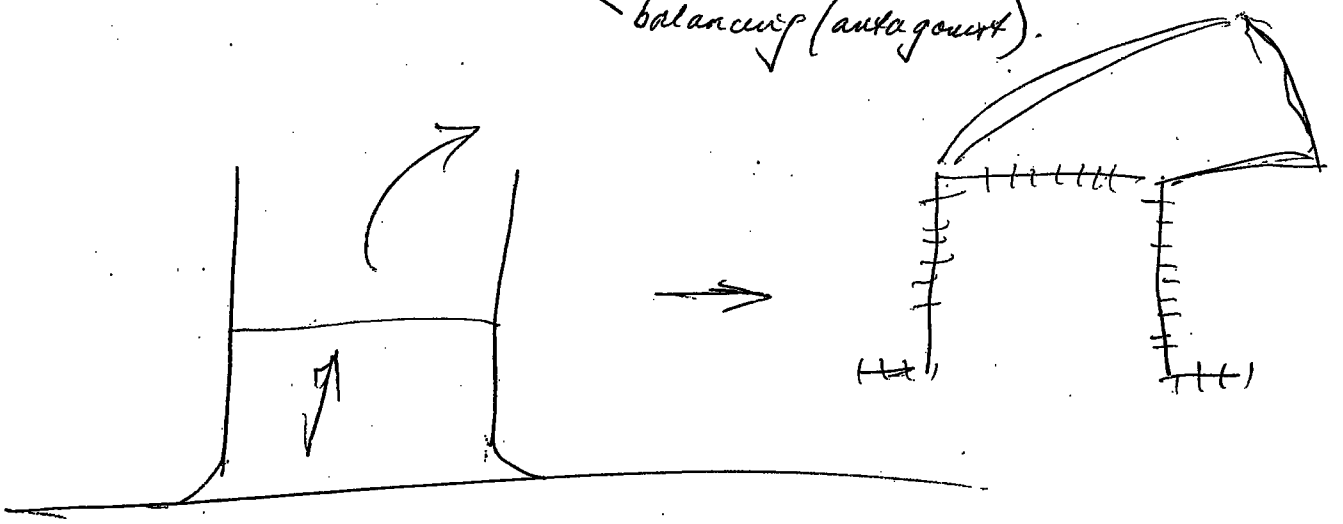
always innervated by M. nerv

lack of full extention *

= dynamic deformity

Setting stage for long flex/ext to work

Muscle function: stabilizes, moves, balancing (antagonist).



* – Impingement of nerv pulp

– Add slides

– other views.

INSTRUCTIONAL COURSE
OPKNAPPINGSKURSUS

1 SEPTEMBER 1991

0800 - 0815	*Registration* *Main Auditorium* *Johannesburg Hospital*	
0815	*Opening Remarks* *Introduction of Prof Ivan B Matev*	*DR S L BIDDULPH*
	CHAIRMAN/VOORSITTER:	***PROF U MENNEN***
0830	*Median Nerve Paralysis*	
	Cases	
	Discussion	
1000	*TEA / TEE*	
	CHAIRMAN/VOORSITTER:	***DR R S BOOME***
1030	*Contractures of the Hand and Boutonniere Deformities*	
	Cases	
	Discussion	
1200	*Distraction Method in Reconstruction of the Thumb*	
	Cases	
	Discussion	
1300	*LUNCH / MIDDAGETE*	
	CHAIRMAN/VOORSITTER:	***DR J FLEMING***
1400	*Surgery of the Spastic Hand*	
	Cases	
	Discussion	
1530	*TEA / TEE*	
	CHAIRMAN/VOORSITTER:	***DR D MACKAY***
1600	*Tendon Transfers*	
	Cases	
	Discussion	
1730	*Cocktail party* *Emoyeni*	

NOTES

ADDRESS LIST OF SPEAKERS
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