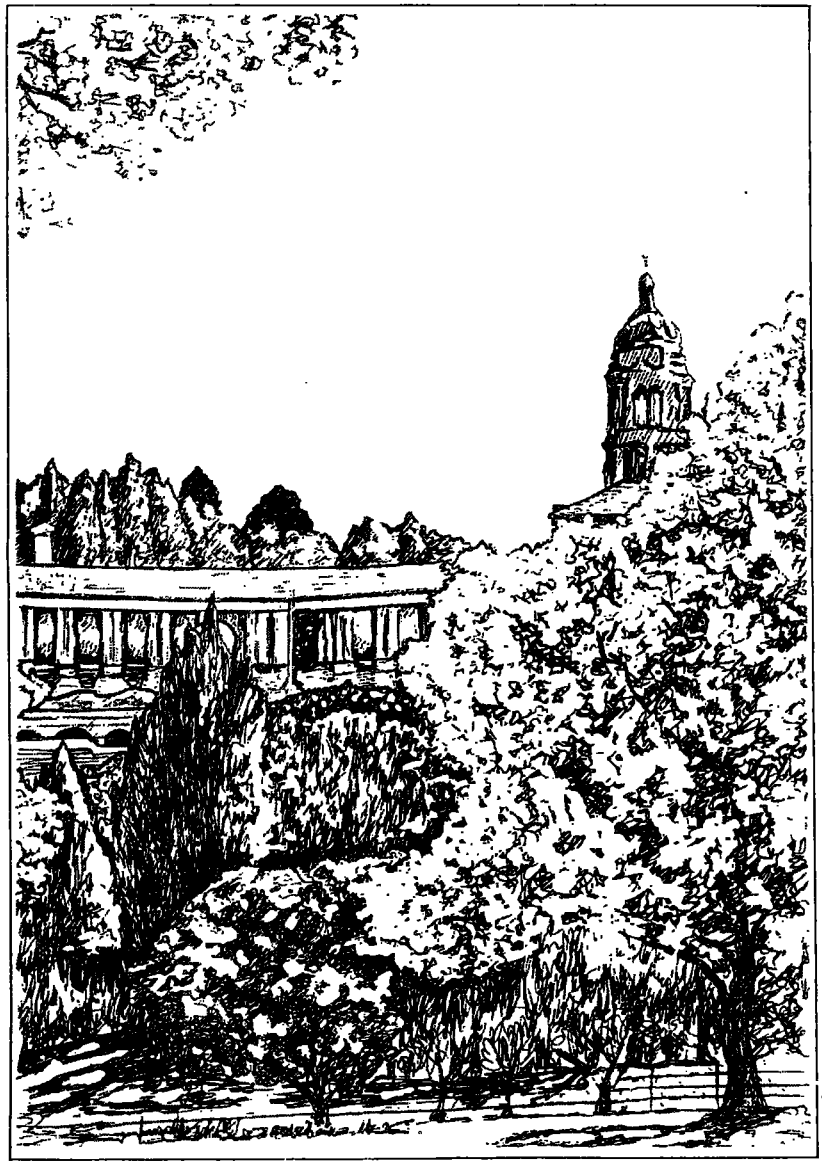
S A Society for Surgery of the Hand

S A Vereniging vir Handchirurgie

CONGRESS AND INSTRUCTIONAL COURSE

KONGRES EN OPLEIDINGSKURSUS

1989



Venue Sinodale Sentrum Pretoria

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CONGRESS ORGANIZER
KONGRES ORGANISEERDER 1989

U. MENNEN

ANNUAL GENERAL MEETING
ALGEMENE JAARVERGADERING

4 SEPTEMBER 1989

16h15 — 17h30

(members only/lede alleenlik)

— 1 —
Welcome address by the President
Verwelkoming deur die President
— 2 —
Apologies
Verskonings
— 3 —
Proxies
Volmagte
— 4 —
Minutes of the previous Annual General Meeting
Notule van die vorige Algemene Jaarvergadering
— 5 —
Matters arising from the minutes
Sake wat uit die notule voortspruit
— 6 —
President's report
President se verslag
— 7 —
Honorary Secretary/Treasurer's report
Ere-Sekretaris/Tesourier se verslag
— 8 —
Proposed increase in Entrance Fee and Annual Subscription
Voorgestelde verhoging in Intreefooi en Jaargeld
— 9 —
Announcement of new Executive Committee members for the period September 1989 - September 1991
Aankondiging van nuwe Uitvoerende Bestuurslede vir di tydperk September 1989 - September 1991
— 10 —
Announcement of new members
Aankondiging van nuwe lede
— 11 —
General
Algemeen
— 12 —
Next Annual General Meeting
Volgende Algemene Jaarvergadering

SOCIAL EVENTS
SOSIALE BYEENKOMSTE

3 SEPTEMBER 1989

18h00 — 21h00

BRAAI

(delegates and partners/
afgevaardigdes en metgeselle)

ROODEVALLEI RESTAURANT
KAMEELDRIFT
PRETORIA

Buses depart from Burgerspark Hotel at 17h30
Busse vertrek vanaf Burgerspark Hotel om 17h30

4 SEPTEMBER 1989

19h00 for/vir 19h30

BANQUET/BANKET

(delegates and partners/
afgevaardigdes en metgeselle)

BOULEVARD HOTEL
STRUBEN STREET/STRAAT
PRETORIA

Buses depart from Burgerspark Hotel at 18h30
Busse vertrek vanaf Burgerspark Hotel om 18h30

INSTRUCTIONAL COURSE
OPKNAPPINGSKURSUS

SUNDAY/SONDAG 3 SEPTEMBER 1989

presented by/aangebied deur

DR. R.M. McFARLANE
LONDON, ONTARIO
CANADA

and/en

DR. D.A. McGROUTHER
BEARSDEN, GLASGOW

07h30 — 08h30	Registration/Registrasie: NG Sinodale Konferensiesentrum

DR R.M. McFARLANE

08h30 — 09h15	Dupuytren's disease — general lecture
09h15 — 09h20	Discussion/Bespreking
09h20 — 09h55	Aetiology and pathology of Dupuytren's disease
09h55 — 10h00	Discussion/Bespreking
10h00 — 10h30	Tea/Tee
10h30 — 11h05	Anatomy of Dupuytren's disease
11h05 — 11h10	Discussion/Bespreking
11h10 — 11h45	Dupuytren's disease, work and injury
11h45 — 11h50	Discussion/Bespreking
11h50 — 12h25	Treatment of Dupuytren's disease
12h25 — 12h30	Discussion/Bespreking
12h30 — 13h30	Lunch/Middagete
13h30 — 14h05	Post-operative management of Dupuytren's disease (for therapists)
14h05 — 14h10	Discussion/Bespreking

DR. D.A. McGROUTHER

14h10 — 14h30	Skin cover in the hands
14h30 — 14h35	Discussion/Bespreking
14h35 — 14h55	Reconstruction of the mutilated hand
14h55 — 15h00	Discussion/Bespreking
15h00 — 15h30	Tea/Tee
15h30 — 15h55	Rheumatoid deformity
15h55 — 16h00	Discussion/Bespreking
16h00 — 16h25	Hand tumours
16h25 — 16h30	Discussion/Bespreking
18h00 — 21h00	Braai Roodevallei Restaurant, Kameeldrift, Pretoria (delegates and partners/ afgevaardigdes en metgeselle)

CONGRESS
KONGRES

MONDAY/MAANDAG 4 SEPTEMBER 1989

07h00 — 07h45	Registration/Registrasie N.G. Sinodale Konferensiesentrum
08h00 — 08h05	Welcome and announcements Verwelkoming en aankondigings
08h05 — 09h55	Scientific presentations Wetenskaplike voordragte
09h55 — 10h30	Tea/Tee
10h30 — 13h00	Scientific presentations Wetenskaplike voordragte
13h00 — 14h00	Lunch/Middagete
14h00 — 15h05	Scientific presentations Wetenskaplike voordragte
15h05 — 15h30	Tea/Tee
15h30 — 16h00	Scientific presentations Wetenskaplike voordragte
16h15 — 17h30	Annual General Meeting (members only) Algemene Jaarvergadering (slegs lede) (Venue/Plek: N.G. Sinodale Konferensiesentrum)
19h00	Banquet (delegates and partners) Banket (afgevaardigdes en metgeselle) (Venue/Plek: Boulevard Hotel)

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

4 SEPTEMBER 1989 — PRETORIA

07h00 — 07h45	Registration/Registrasie N.G. Sinodale Konferensiesentrum
08h00 — 08h05	Welcome and announcements Verwelkoming en aankondigings
	CHAIRMAN/VOORSITTER: DR K.S. NAIDOO
08h05 — 08h30	Cumulative Trauma Disorders — DR R.M. McFARLANE
08h30 — 08h40	Discussion/Bespreking
08h40 — 08h50	Ulnar nerve palsy following fractures of the distal radius — DR. A.C. CLARKE, DR. R.F. SPENCER
08h50 — 08h55	Discussion/Bespreking
08h55 — 09h05	Managing metacarpal shaft fractures and the clamp-on plate — PROF. U. MENNEN
09h05 — 09h10	Discussion/Bespreking
09h10 — 09h20	Management of scaphoid fractures at 1 Military Hospital — DR. A.J. WIENAND
09h20 — 09h25	Discussion/Bespreking
09h25 — 09h35	Bone graft donor site: Ilium or radius? — DR. S. BIDDULPH, DR. C.M. SCHNITZLER
09h35 — 09h40	Discussion/Bespreking
09h40 — 09h50	Scaphoid fractures: A review of 150 cases — DR. R. NACHEF, DR. S.L. BIDDULPH, DR. E. SCHNAID
09h50 — 09h55	Discussion/Bespreking
09h55 — 10h30	Tea/Tee
	CHAIRMAN/VOORSITTER: DR. A. J. WIENAND
10h30 — 10h40	Extensor indicis proprius: A special gift for hand surgeons — DR. J.H. FLEMING
10h40 — 10h45	Discussion/Bespreking
10h45 — 10h55	Principles in reconstructing the burned hand — DR. E. BOWEN-JONES
10h55 — 11h00	Discussion/Bespreking
11h00 — 11h10	The post-operative stiff hand: An iatrogenic condition? — DR. M. MARS
11h10 — 11h15	Discussion/Bespreking
11h15 — 11h25	Profile of human bite injuries of the hand at Ga-Rankuwa Hospital: A study of 100 cases — PROF. U. MENNEN, C.J. HOWELLS
11h25 — 11h30	Discussion/Bespreking

11h30 — 11h40	Capito-Lunate instability of the wrist — DR. W. KOHNKE
11h40 — 11h45	Discussion/Bespreking
11h45 — 11h55	Short term effects of Kirschner wires on rat femurs — DR. R. RAJOO
11h55 — 12h00	Discussion/Bespreking
12h00 — 12h10	An arthrographic study of the radiocarpal joint: A report on 107 cases — DR. N.M. FREED
12h10 — 12h15	Discussion/Bespreking
12h15 — 12h25	Dynamic splints: Magnitude of force — MISS C. VAN VELZE
12h25 — 12h30	Discussion/Bespreking
12h30 — 12h50	Camptodactyly — DR R.M. McFARLANE
12h50 — 13h00	Discussion/Bespreking
13h00 — 14h00	Lunch/Middagete
	CHAIRMAN/VOORSITTER: DR. S.L. BIDDULPH
14h00 — 14h20	Presidential address — DR. K.S. NAIDOO
14h20 — 14h30	Toe-to-hand free tissue transfers for thumb reconstruction — DR. C.J. BARNARD
14h30 — 14h35	Discussion/Bespreking
14h35 — 14h45	Fingertip reconstruction — DR. KUO-HWA CHANG
14h45 — 14h50	Discussion/Bespreking
14h50 — 15h00	Double-toe to hand transfer — DR. B.J. v. R. ZEEMAN
15h00 — 15h05	Discussion/Bespreking
15h05 — 15h30	Tea/Tee
	CHAIRMAN/VOORSITTER: PROF. U. MENNEN
15h30 — 15h55	Amputations — DR. R.M. McFARLANE
15h55 — 16h00	Discussion/Bespreking
16h00 — 16h05	Closure of congress /Afsluiting van kongres — DR. K.S. NAIDOO
16h15 — 17h30	Annual General Meeting (members only) Algemene Jaarvergadering (slegs lede) (Venue/Plek: N.G. Sinodale Konferensiesentrum)
19h00	Banquet (delegates and partners) Banket (afgevaardigdes en metgeselle) Boulevard Hotel, Struben Street/Straat, Pretoria

SUMMARIES
OPSOMMINGS

Cumulative Trauma Disorders

R.M. McFARLANE

Ulnar Nerve Palsy following Fractures of the Distal Radius

A.C. CLARKE
R.F. SPENCER

A.C. Clarke and R.F. Spencer (Durban) stated that injury to the ulnar nerve was uncommon following fracture at the distal radius. They reported 3 cases of progressive ulnar nerve palsy as a complication of the above fracture.

Two of the fractures were in young adults (one compound) following motor vehicle accidents. The other fracture occurred in an elderly woman. The closed fractures were reduced under a Bier's block and immobilised in a below elbow plaster while the compound fracture was debrided under general anaesthetic and a below elbow plaster applied.

In view of the progressive nature of ulnar palsy all cases were surgically explored. At the same time soft tissue release to improve wrist movement and, in one case, corrective osteotomy was performed. In all cases the ulnar nerve was displaced and compressed in dense scar tissue. In one case the ulnar nerve had dislocated between the distal radioulnar joint as was lying dorsal to it.

Following surgery all cases had a markedly improved range of wrist movement and rapid recovery of ulnar nerve function over 3 - 6 months.

The authors suggest that in cases of progressive ulnar nerve palsy following fractures of the distal radius, early surgical decompression and soft tissue release should be performed.

Managing Metacarpal Shaft Fractures and the Clamp-on Plate

U. MENNEN

Metacarpal fractures are managed by various methods depending on the types of fractures and techniques available. Most metacarpal fractures can be treated conservatively because of their stable nature or because they have little or no influence on function.

Unstable shaft fractures however, present with dorsal angulation and shortening of the ray. These types need some form of stabilisation since manipulation and splinting often result in failure.

The "micro-8" clamp-on plate has been used instead of conventional methods such as Kirschner wires, plates and screws.

Advantages with this method include: very easy technique, short operation time, early unrestricted mobilisation and usage of the hand, full functional recovery, uneventful heal-'ng and union, needless second removal operation and simple instrumentation.

This method can therefore be strongly recommended for metacarpal shaft fractures, especially when consideration is given to instrumentation cost, operation time, surgical skill, hand morbidity, second operations and the complexity of comminuted fractures.

Management of Scaphoid Fractures at 1 Military Hospital

A.J. WIENAND

The results of the treatment of over 100 scaphoid fractures treated at 1 Military Hospital are presented. The results should be judged by the patient's functional ability and not solely on the union rate.

Proximal pole fractures present the biggest problems.

The question of when and if one should operate is addressed.

Stable non-unions are treated conservatively.

Bone Graft Donor Site: Ilium or Radius?

S.L. BIDDULPH, C.M. SCHNITZLER

The aim of this study is to establish whether the distal radius provides suitable bone graft material for the hand, thus saving the patient an additional operation on the ilium. We compared iliac with distal radial (dorso-lateral) bone obtained from 7 patients (3 male, 4 female, aged 26-66 years) at the time of wrist surgery. The bone specimens were examined undecalcified by routine histomorphometry. Three patients (mean age 33 years, 2 non-union of scaphoid, 1 Kienböck's) who had not had recent wrist surgery, had similar or greater bone volume and trabecular thickness in the radius compared with the ilium, whereas 4 older patients (mean age 50 years, 3 inflammatory arthritis, 1 recent wrist surgery for old fractured radius) had lower values in the radius than the ilium.

These preliminary findings suggest that the distal radius provides good graft material in young individuals with carpal trauma and who have not undergone recent wrist surgery, but that in older patients, especially in those with inflammatory synovitis of the wrist or with recent wrist surgery, the ilium is the better donor site.

Scaphoid Fractures — A review of 150 Cases

R. NACHEF, S.L. BIDDULPH, E. SCHNAID

One hundred and fifty cases of scaphoid fractures were reviewed with 9 years follow-up (between 1980 and 1988).

Emphasis is placed on the following aspects:

Age
Sex
Mechanism of injury
Type of fracture
Time interval before diagnosis
Treatment — plaster cast
bone graft
implant
Follow-up and results

Extensor Indicis Proprius — A Special Gift for Hand Surgeons

J.H. FLEMING

The choice of tendon to be transferred is a balance of availability, amplitude, power and synergism.

We are fortunate in having a tendon which has independence, innovation, good amplitude and reasonable power. Its position, deep to the extensor tendons often shelters it from major lacerations. There is minimal deficit caused by its use as a tendon transfer.

Extensor indicis proprius is an excellent choice for 4 major tendon transfers: Adduction of thumb
Opposition of thumb
Replacement of extensor pollicis longus
Mass extensor extension of fingers

Suitable examples will be demonstrated.

Principles in Reconstructing the Burned Hand

E.J. BOWEN-JONES

Many patients are referred to our Unit with severe hand deformities following burns, where hand function can be described as little better than that of a 'flipper'.

Our experience has shown that considerable improvement in hand function can be achieved by very simple surgery. A radical release of the thumb web space to move the thumb into opposition and of the hand in all directions is followed by Kirschner wire fixation and thick split skin grafting. Kirschner wires are removed after 3-4 weeks and mobilisation is commenced.

Flaps are not necessary to release the thumb web space but will be necessary to resurface the dorsum of the hand and fingers prior to arthrodesis of joints in a functional position.

If a thumb is missing, a reconstruction rather than phalangisation is essential. The psychological benefit of creating an aesthetically acceptable hand motivates a patient to use it rather than hide it.

Statistics and photographs of a personal series will be presented demonstrating recovery of useful hand function.

The Post-operative Stiff Hand: An Iatrogenic Condition?

M. MARS

Post-operative oedema of the hand is a normal physiological response to injury. This study examines the effect of 2 routine procedures in hand surgery — tourniquet use and compression bandaging — on oedema formation. Tourniquet ischaemia causes venous acidosis in the limb which increases vascular permeability, predisposing to oedema formation. Based on normal venous haemodynamics, it can be postulated that a compression bandage that excludes the fingers will result in oedema of the fingers and furthermore, that the magnitude of the oedema is directly related to the pressure generated by the compression bandage on the hand and forearm.

This concept was confirmed in 10 normal volunteers, by applying a below elbow compression bandage which excluded the fingers. The pressure under the bandage was continuously monitored and maintained at 20mmHg for 8 hours. The volume of the fingers was measured before bandaging and after 8 hours, by the fluid displacement method. The experiment was repeated 24 hours later with the subject putting on a surgical glove, prior to bandaging. The glove served to raise the venous pressure in the fingers, mimicking the effect of oedema and this reduced the percentage change in hand volume caused by the compression bandage.

This evidence indicates that compression bandaging may be a factor in the genesis of the stiff hand after surgery. It is suggested that this effect may be lessened by routinely deflating the tourniquet and gaining meticulous haemostasis before wound closure thus obviating the need for post-operative compression.

Profile of Human Bite Injuries of the Hand at Ga-Rankuwa Hospital

U. MENNEN, C.J. HOWELLS

The human bite injury and "fist-fight" injury of the hand are supposed to be emergency injuries seen at outpatients and casualty centres. These injuries however, are not dealt with in this manner, since the seriousness of the "obviously innocent" injury is not realised by the patient and often not by the doctor.

The literature shows that the occurrence of human bite injuries of the hand will vary from place to place and is seen in various sections of society and in different age groups. The occurrence is also determined by the rural and urban environment.

This study was characterised by a large number of patients who presented for treatment more than 1 week after the injury, and therefore had a high complication rate. The average hospital stay was 10 days. The severity of the complications has a direct correlation with the time interval between the bite injury and treatment as well as the method of treatment.

The method of treatment includes the following:
— immediate, thorough wound debridement (regardless of size and severity)
— wound baths 4 times per day
— antibiotic therapy (Cloxacillin 1gm 6hrly/os, Metronidazole 400mg 8hrly/os and Gentamycin 80mg 8hrly/im)
— hand elevation
— intensive mobilisation

The cases who presented at hospital early (within 24 hours after injury) and were managed according to the above regime, stayed in hospital for an average of 3 days with a full recovery in less than 7 days.

Capito-lunate Instability of the Wrist

W. KOHNKE

Two patients with pain and clicking of the wrist are presented. Cineradiography demonstrated a dorsal subluxation of the capitate on stressing the carpus.

After failed conservative treatment, surgical stabilization according to Johnson and Carrera was performed by closing the space of Poirier.

No pain or clicking was experienced at one year post-surgery, but there was slight loss of movement at the wrist. Repeat cineradiography demonstrated a stable wrist.

Short Term Effects of Kirschner Wires on Rat Femurs: An Experimental Study

R. RAJOO

The aim of this study was to determine the adverse effect of Kirschner wires inserted by power drill on skin, bone and muscle, the radius of destruction and whether these changes reversed with time.

Kirschner wires were inserted into femurs of 20 adult rats, using a medical electric drill. Two types of wires were used: stainless steel and vitallium. Two sizes of wires were inserted percutaneously. The wires were trimmed so that they did not protrude through the skin.

The wires were left in situ for varying periods of time (up to 8 weeks), at the end of which the animals were sacrificed. Specimens of bone, muscle and skin adjacent to the Kirschner wires were subjected to histological and electron-microscopic examination.

The nature of the changes evoked in skin, muscle and bone and the depth of the changes are demonstrated.

An Arthrographic Study of the Radiocarpal Joint: A Report on 107 Cases

N.M. FREED

The purpose of the study:

1. To define the normal arthrographic anatomy of the proximal radiocarpal joint
2. To define intracarpal ligamentous damage
3. To diagnose injury to the triangular ligament
4. To diagnose intracarpal space occupying lesions such as ganglia
5. To detect injury to the triangular ligament
6. To decide if this investigation was helpful in the early diagnosis of carpal instability

The method of investigation:

All investigations are conducted under strict aseptic conditions in an IVP theatre with continuous screening facilities availabile.

The anatomical findings:

Our findings agree with those previously published, however, we have found an apparently normal communication between the proximal radiocarpal joint and the midcarpal joint via the pisotriquetral joint.

Abnormal arthrograms including the following:

The most common lesion found was a tear of the scapholunate ligament; The next most common lesion diagnosed was tears of the triangular ligament; The next lesion detected was tears of the lunatriquetral ligament; Another finding was the presence of space occupying lesion.

Complications:

No serious complications were encountered.

Conclusions:

The wrist arthrogram is a safe and easy procedure. The maximal benefit of this investigation is the diagnosis of scapholunate ligamentous tears. An apparently normal communication between the pisotriquetral joint and the midcarpal joint has been identified.

Dynamic Splints: Magnitude of Force

MISS C. VAN VELZE

Low profile dorsal dynamic finger extension splints have been used for many years to improve the length of the extrinsic finger flexors and to decrease tendon adhesions.

The amount of force required to influence growth and collagen alignment has always been determined intuitively and therapists have relied on their feeling when fitting a patient with a dynamic splint.

The aim of the study was to determine the magnitude of force exerted on the finger using the above splint. (The force is supplied by elastic bands).

The force is dependant on:

— length and quality of the elastic band
— quality of rubber
— time the elastic band is under tension

The above factors were analysed in a laboratory situation and it was found that friction over the outrigger has a considerable influence of the actual force exerted on the finger.

Different materials were compared to see which ones would cause the least friction. It was found that nylon fishing line which runs over a teflon covered outrigger causes the least friction.

The method used, analysis of data and clinical implications of the study will be discussed.

Camptodactyly

R.M. McFARLANE

Toe-to-hand Free Tissue Transfer for Thumb Reconstruction

C.J. BARNARD

The importance of a carefully selected and well executed program of surgery when dealing with mutilating injuries of the thumb needs no emphasis.

During the last decade microsurgical free toe transfer has become a reliable and acceptable procedure and, with pollicisation and osteoplastic reconstruction, established itself as the method of choice in selected circumstances.

Refinements in technique, addressed to donor site morbidity as well as improved function and appearance of the transplanted digit, resulted in a variety of procedures — each maintaining its own usefulness and superiority. The beginner in the field might find this a bit confusing and may have problems to decide which method to use. Those experienced with the technique will agree to the diversity of factors to consider once the decision of a toe-to-hand transfer has been made.

This paper represents a personal experience with 31 free toe-to-hand transfers done by the extremity reconstruction team of the Chang Gung Memorial Hospital in Tapei. By means of illustrative case reports, an outline is given of the variety of options available when considering a toe transfer procedure.

Current criteria are presented to help select the appropriate method which will fulfil the functional demands as well as the desires of the patient.

Fingertip Reconstruction

KUO—HWA CHANG

Fingertip reconstruction with special attention to the establishment of a finger nail with normal function and appearance is described.

The author also discusses his experience in the treatment of 52 injured fingertips.

Double-toe to Hand Transfer

B.J. van R. ZEEMAN

The loss of multiple fingers from a hand is a mutilating injury, leaving the patient with limited hand function. When this occurs in both hands, the patient is almost a cripple.

Two cases are presented describing the indications and technique in reconstructing losses at the metacarpophalangeal level. It is important to note that it is almost impossible to reconstruct a functional finger, a nail, normal pulp and accurate sensation without using another finger or a toe by free microneurovascular transfer.

Case one

A farmer who suffered from a congenital abnormality of his L. thumb, lost 4 fingers of his dominant hand after a mechanical injury and was left with a thumb only.

Case two

A housewife suffered severe burn injuries of both hands after a primus stove had exploded and was left with 2 thumbs only.

The one patient experienced delayed wound healing of the foot; no other major complications occurred.

The improvement in hand function of both patients is discussed.

Amputations

R.M. McFARLANE

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ERKENNINGS

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is co-guest of the SASSH, SAOA and MRC
is mede-gas van die SAVH, SAOV en MNR

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MNR het ruim tot die uitgawes van Dr McFarlane bygedra

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