

HAND SURGERY

QUARTERLY



FROM THE EDITOR'S DESK

A Sense of Purpose

Every organization, if it is to survive and be successful, must have a purpose with which its members can identify. This purpose, otherwise known as the mission, goal, or vision of the organization, is critical in defining the essential nature of the organization, and is essential to keeping the organization on track. Many organizations have run into trouble by losing sight of their purpose, and wandering into areas that diverge from the essential mission of the organization. The result is

PETER C. AMADIO, MD

often disenchantment of the members, lack of interest and commitment by the staff, and, in extreme cases, dissolution of the organization. It was my privilege from 1998 to 1999 to serve as President of the American Association for Hand Surgery. I believe our organization provides a good example of an association that chose its purpose well, and has kept close to its initial purpose. The AAHS mission statement is "To promote the highest quality of hand care through educational programs, and through the endowment of research." The AAHS is interest-

ed in hand care, not hand surgery; membership includes both hand surgeons and hand therapists. AAHS sponsors an annual scientific meeting, which is typically held in a pleasant resort environment. Costs tend to be considerably lower than those seen in other organizations: the annual professional dues are currently \$275 per year.

Nevertheless, the quality of the annual meeting tends to be quite high. Cost controls are maintained because the AAHS focuses entirely on its educational mission, and does not have, for example, a publishing arm, a lobbying arm, or other subsidiary operations which may drain the time, talent, and treasure of its members.

Professional organizations lose their way when they try to be all things to all people, when they grow for growth's sake, when too much activity is delegated from the volunteer leadership to the full time staff, when there is inertia within the full time staff, or when constituents become disinterested because the organization is no longer serving their needs. A charismatic executive director may impose a personal agenda. The organization may fail to focus on attainable needs and instead of trying to form a "more perfect" society, may inappropriately focus on a state of perfection which is not attainable and which only produces frustration in those who strive for it.

The phrase "that which governs least governs best" has a kernel of truth within it. Bureaucracies tend to stifle, are costly, and often hinder progress.

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Organizations in general do not benefit from bureaucracy, but instead from constant reminders of the purpose of the organization and a regular review of the members' needs to be sure that the needs and mission of the organization are in synchrony. And while simply stated, clearly focused goals (KISS—keep it simple, stupid) are often the hallmark of successful organizations, lofty goals beyond the means of the organization can be the kiss of death for small organizations that try to do too much. Small organizations are not typically cut out to be publishers, have no way to be an effective political force, and cannot serve as major sources of research funding. Why try? It would be better for small organizations to focus on things

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EDITOR'S DESK

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they can do such as member education, and leave publishing to the publishing houses, politics to larger organizations, and research funding to better endowed groups.

Another kiss of death for organizations is ever-changing or ever-expanding ambitions of an organization, which I would call the Presidential Legacy Syndrome. In many organizations the presidency rotates every year. Each president naturally wishes to leave a legacy for their term in office. As a result each president starts a project or several projects. Unfortunately, few presidents ever stop projects or reorganize the association by reducing rather than increasing the number of committees, staff appointments, and so forth. As a result organizations tend to grow erratically over time. It would be better if more presidents were to consider leaving as a legacy a more streamlined and efficient organization. Unlike many other organiza-

tions, over the last few years, the American Association for Hand Surgery presidential line has worked hard to do just that, and has succeeded in reducing organizational expenses by 20 to 30 percent, as well as streamlining the leadership process, so that Board meetings which used to take two days are now completed in a half day, with more substantive matters attended to.

Organizations should grow only when this is appropriate to satisfy the purpose of the organization and to serve the needs of its members. Growth in order to provide funds for staff raises, staff promotions, and career advancement for permanent staff members is not appropriate. It is certainly appropriate to attend to the human needs and well-being of the staff, but when these come into conflict with the basic purpose of the organization, then it may be better to reconsider whether the staff is appropriate to the organization rather than vice versa.

The foregoing was not intended to imply that organizations need to

limit themselves exclusively to activities that they can complete on their own. Strategic alliances are certainly appropriate and these are especially useful for medical organizations in the areas of education, public advocacy, and to promote other professional issues such as quality of care. Again, I believe that the American Association for Hand Surgery represents a good example of just this sort of alliance building. AAHS has been willing to form relationships with other like-minded organizations to accomplish both major and minor goals. Rather than go through the cumbersome process of certification to offer continuing medical education credits, AAHS has partnered with other organizations, such as the Plastic Surgery Education Foundation and the American Society for Surgery of the Hand, that do this. This has reduced overhead expenses, because the certification process is cumbersome and often requires retention of a full time employee simply to manage this one aspect of the organization. AAHS has partnered with a variety of organizations including the American Society for Reconstructive Microsurgery, the American Society for Surgery of the Hand, and the American Society for Peripheral Nerve to improve educational content by leveraging with the expertise of other organizations, while simultaneously reducing overall expenses for all involved. AAHS has formed an alliance with the Orthopaedic Research and Education Foundation to fund research jointly. AAHS has also cooperated with the American Society for Surgery of the Hand in the AMA House of Delegates, where AAHS and ASSH currently share an AMA delegate position.

I encourage each of you to consider what your own purpose might be, how to keep it simple and focused, and how best to achieve it. As Benjamin Rush counseled his son: "While I would thus wish to direct attention to everything..., always recollect that your first duties will be to the sick". Find

Call for Nominees

The Clinician/Teacher of the Year Award is given annually to an AAHS member that has made significant contributions to the field of hand surgery in the area of teaching. As the President-Elect, I have the responsibility for selecting the recipient of the 2001 award. This year, I will select the recipient from nominations from you. The nominations should adhere to the following guidelines:

1. The nominee should be a member of the American Association for Hand Surgery (active, affiliate, retired, international).
2. The nominee does not have to be actively teaching. The longer the nominee has taught and the more lives he or she has touched the better. However, your reasons for making the nomination can be very personal.
3. The letter of nomination should be NO MORE than one typed page.
4. The letter should contain your reasons for believing that the nominee deserves the award and what the nominee and his/her teaching has meant to you.
5. The letter must be signed.

The winner will be selected from letters submitted. In presenting the award, part of the letter will be read. Although we need your name to consider the nomination, we do not have to reveal your identity at the presentation.

Robert T. Buchanan, MD

Work Plan Initiatives Bring Progress

The summer months of 2000, from an administrative perspective, have focused on the mid-year Board Meeting. The meeting will occur mid July, a few weeks after writing this column. This presents an opportunity to share some of my thoughts on our Association's progress through the first six months of the year.

In the year 2000 we embarked on our Strategic Plan, which I have previously reviewed in the President's message. In the first six months of this plan we, referring to

our administrative staff, committees and board members, have accomplished nearly all of our short-term work goals. This is a considerable and gratifying accomplishment, with substantial benefit for AAHS and our membership. The Strategic Plan, though, imposes considerable change on our organization. It changes the content of Board Meetings, our format for deliberation, and the way we interact with our management team. Strategic planning is also a dynamic process and requires continuous review and revitalization. Your board members will be devoting additional time and effort this year to make this possible.

The summer Board Meeting will also be our first opportunity to assess three important initiatives that I have encouraged for the year 2000. These initiatives include Internet applications, international membership development, and an overall review of our committee structure, in view of the Strategic Plan. Dr. Keith Brandt has done an outstanding job of moving our Internet applications forward. Already we have available a member roster; Annual Meeting information and registration capabilities; and for the first time, for the 2001 Annual Meeting, abstracts were submitted and rated on line. Additional and substantial Internet application's proposals will be considered by the Board at the summer meeting. Dr. Alan Freeland and his committee are also prepared to present a set of innovative proposals to encourage international membership development within AAHS. These proposals, if effected, would encourage international members' participation as well as the content and organization of our 2002 Annual Meeting. Peter Amadio and his Committee on Committees took an overdue look at our committee structure, especially in view of our Strategic Plan. His committee has

also offered a number of suggestions to streamline our administrative structure and facilitate our efficiency.

Attention to the Annual Meeting is a year-long process for the administrative staff and president. As I mentioned previously, the Program Committee is doing an outstanding job of exploring some novel programming ideas and facilitating participation in the Annual Meeting by a broad representation of our membership. Dr. Baratz and his committee are especially attuned to involving residents and fellows in the educational programming. I am pleased to note that the number and quality of abstracts this year are excellent. I am especially and personally pleased with the truly outstanding invited speakers for the Annual Meeting 2001.

Dr. Joseph Buckwalter, chairman of the Department of Orthopaedics from the University of Iowa, is my Invited Lecturer for AAHS. He will address recent scientific advances and their implications for musculoskeletal care. The AAHS and ASRM combined Presidents' Invited Lecturer is Dr. Michael Wood, President and CEO of the Mayo Foundation. Dr. Wood is one of our country's leading thinkers concerning medical and economic development in medical care delivery systems. As we continue to finalize the Annual Meeting, I again invite all AAHS members and nonmembers as well to attend the Annual Meeting in San Diego. I can personally assure you in advance that the program will be highly educational and conducted in a warmly social environment. **H**

WILLIAM F. BLAIR,
MD

HAND SURGERY QUARTERLY

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Hand Surgery Quarterly is a publication of The American Association for Hand Surgery and is published strictly for the members of AAHS. This publication is designed as a forum for open discussion and debate among the AAHS membership. Opinions discussed are those of the authors or speakers and are not necessarily the position, posture or stance of the Association.

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AAHS 31ST ANNUAL MEETING

JANUARY 10-13, 2001
LOEWS CORONADO BAY RESORT
SAN DIEGO, CA

Program at a Glance

AAHS 31st Annual Meeting

Wednesday, January 10, 2001

| | |
|-------------------|--|
| 6:30 am - 5:00 pm | Speaker Ready Room |
| 7:00 am-8:00 am | Hand Therapy Pre-Conference Registration and Coffee |
| 8:00 am-5:30 pm | Hand Therapy Pre-Conference Seminar |
| 1:00 pm-5:00 pm | AAHS Board Meeting |
| 1:00 pm-5:00 pm | Poster Set Up |
| 12:00 pm- 1:20 pm | Hand Therapy Lunch |
| 12:00 pm-5:00 pm | AAHS Annual Meeting Registration |

Thursday, January 11, 2001

| | |
|-------------------|--|
| 6:30 am-5:00 pm | Speaker Ready Room |
| 6:30 am-4:30 pm | AAHS Registration |
| 6:30 am-7:00 am | Coffee |
| 7:00 am-5:00 pm | Posters Open |
| 7:00 am-7:03 am | President's Welcome <i>William Blair, MD</i> |
| 7:04 am-7:07 am | ASSH President |
| 7:08 am-7:10 am | Program Chair's Welcome <i>Mark Baratz, MD</i> |
| 7:10 am-7:30 am | Report from the 2000 Vargas Award Winner |
| 7:30 am-8:38 am | Scientific Paper Session A |
| 8:38 am-8:53 am | Coffee Break |
| 8:53 am-10:30 am | Concurrent Scientific Paper Session B-1 |
| 8:53 am-10:30 am | Concurrent Scientific Paper Session B-2 |
| 10:30 am-11:30 am | Panel I: <i>Simple Fractures That Aren't</i> |
| 11:30 am-12:00 pm | Presidential Invited Lecture <i>Joseph Buckwalter, MD</i> |

| | |
|------------------|---|
| 12:00 pm-1:00 pm | Lunch Break |
| 1:00 pm-2:45 pm | Scientific Paper Session C |
| 3:00 pm-4:00 pm | Panel II: <i>Flexor Tendon Injuries</i> |
| 4:00 pm-5:00 pm | Instructional Courses 101-106 |
| 7:00 pm-9:00 pm | AAHS Welcome Reception |

Friday, January 12, 2001

| | |
|-------------------|--|
| 6:30 am-5:00 pm | Speaker Ready Room |
| 6:30 am-12:00 pm | AAHS Registration |
| 6:30 am-7:00 am | Coffee |
| 7:00 am-5:00 pm | Posters Open |
| 7:00 am-7:45 am | Instructional Courses 107-112 |
| 8:00 am-9:04 am | Scientific Paper Session D |
| 8:30 am-2:00 pm | Exhibits Hall Open |
| 9:04 am-9:39 am | Coffee/Exhibits Break |
| 9:39 am-11:08 am | Concurrent Scientific Paper Session E-1 |
| 9:39 am-11:08 am | Concurrent Scientific Paper Session E-2 |
| 11:15 am-12:15 pm | Panel III: <i>The Cut Nerve</i> |
| 12:15 pm-1:15 pm | Awards Luncheon/Presidential Address |
| 1:15 pm-1:45 pm | AAHS Business Meeting |
| 1:15 pm-6:15 pm | Resident Papers/Panel/Finger Bowl |
| 1:45 pm-2:45 pm | AAHS Board Meeting |
| 2:45 pm-6:15 pm | ASRM Council Meeting |
| 5:00 pm-9:00 pm | ASPN Poster Set Up |
| 6:30 pm-9:30 pm | ASPN Council Meeting |

AAHS/ASPN/ASRM Joint Day Program

Saturday, January 13, 2001

| | |
|-------------------|--|
| 6:30 am-5:00 pm | Speaker Ready Room |
| 6:30 am-7:00 am | Coffee |
| 6:30 am-4:30 pm | AAHS/ASRM/ASPN Registration |
| 7:00 am-8:00 am | Instructional Courses 201-204 |
| 7:00 am-5:00 pm | Posters Open |
| 8:05 am-8:15 am | Presidents' Welcome <i>William Blair, MD, AAHS President</i> <i>Saleh Shenaq, MD, ASRM President</i> <i>David T.W. Chiu, MD, ASPN President</i> |
| 8:15 am-9:15 am | Panel I: <i>Functional Free Tissue Transfers for Extremity Reconstruction</i> |
| 9:00 am-2:00 pm | Exhibit Hall Open |
| 9:15 am-9:45 am | Presidents' Lecturer <i>Michael Wood, MD</i> |
| 9:45 am-10:30 am | Coffee/Exhibits Break |
| 10:30 am-11:30 am | Joint Outstanding Nerve Paper Presentations |

| | |
|-------------------|---|
| 11:30 am | AAHS and ASRM Adjourn |
| 11:30 am–12:30 pm | ASPN Breaks |
| 11:30 am | Golf Tournament–Hotel Departure |
| 12:00 pm–5:00 pm | AAHS Poster Tear Down ASRM Poster Set Up |
| 1:00 pm–5:00 pm | ASPN Scientific Session |
| 1:00 pm–2:00 pm | Guest Speaker <i>Richard Ambron, PhD</i> |
| 2:00 pm–3:30 pm | Scientific Session E |
| 3:30 pm–4:00 pm | Coffee Break |
| 4:00 pm–5:00 pm | Guest Speaker: <i>TBA</i> |
| 6:30 pm–8:30 pm | AAHS/ASRM/ASPN Reception |

ASPN Annual Meeting

Sunday January 14, 2001

| | |
|-------------------|---|
| 6:30 am–2:00 pm | ASPN Registration |
| 6:30 am–7:00 am | Coffee |
| 7:00 am–8:00 am | Instructional Courses 401-403 |
| 7:00 am–5:00 pm | Posters Open |
| 8:00 am–8:15 am | Welcome <i>David T.W. Chiu, MD, President</i> <i>Rajiv Midha, MD, Chair</i> |
| 8:15 am–9:00 am | Guest Speaker <i>Tessa Gordon, PhD</i> |
| 9:00 am–10:30 am | Scientific Session F |
| 9:00 am–2:00 pm | Exhibit Hall Open |
| 10:30 am–11:15 am | Coffee Break/Exhibits |
| 11:15 am–12:30 pm | Scientific Session G |
| 12:30 pm–1:15 pm | ASRM/ASPN Nerve Panel: <i>Reflex Sympathetic Dystrophy</i> |
| 1:15 pm–2:15 pm | Poster Exhibit Lunch |
| 2:15 pm–3:45 pm | Symposium: <i>Conduits for Nerve Repair</i> |
| 3:45 pm–5:15 pm | Scientific Session H |
| 5:15 pm–6:00 pm | ASPN Business Meeting |

ASRM Annual Meeting

Sunday January 14, 2001

| | |
|-----------------|---|
| 6:30 am–5:00 pm | Speaker Ready Room |
| 6:30 am–7:00 am | Coffee |
| 6:30 am–2:00 pm | ASRM Registration |
| 7:00 am–5:00 pm | Posters Open |
| 7:00 am–7:08 am | President's Welcome <i>Saleh Shenaq, MD</i> |
| 7:08 am–7:15 am | Program Chair's Welcome <i>Julian Pribaz, MD</i> |

| | |
|-------------------|--|
| 7:15 am–8:00 am | Panel I: <i>Limb Salvage Interface Between New Techniques and Free Tissue Transfer</i> |
| 8:00 am–10:00 am | Scientific Paper Session A |
| 9:00 am–2:00 pm | Exhibit Hall Open |
| 10:00 am–10:45 am | Coffee/Exhibits Break |
| 10:45 am–12:00 pm | Scientific Paper Session B |
| 12:00 pm–12:30 pm | Presidential Address <i>Saleh Shenaq, MD</i> |
| 12:30 pm–1:15 pm | ASRM/ASPN Nerve Panel: <i>Reflex Sympathetic Dystrophy</i> |
| 1:15 pm–5:45 pm | Resident/Fellows Symposium |

Monday January 15, 2001

| | |
|-------------------|--|
| 6:30 am–5:00 pm | Speaker Ready Room |
| 6:30 am–2:30 pm | ASRM Registration |
| 6:30 am–7:00 am | Coffee |
| 7:00 am–8:00 am | Instructional Courses 301–306 |
| 7:00 am–1:00 pm | Posters Open |
| 8:00 am–8:45 am | Panel II: <i>Gene Therapy Research and Applications in Reconstructive Microsurgery</i> |
| 8:30 am–2:00 pm | Exhibits |
| 8:45 am–9:30 am | Godina Lecture |
| 9:30 am–10:15 am | Coffee/Exhibits Break |
| 10:15 am–12:15 pm | Concurrent Scientific Paper Session C-1 |
| 10:15 am–12:15 pm | Concurrent Scientific Paper Session C-2 |
| 12:15 pm–1:00 pm | Panel III: <i>Surgical Engineered and Customized Free Flap Transfer</i> |
| 1:00 pm–1:30 pm | Founders' Lecture |
| 1:00 pm–5:00 pm | Audio Visual Theater |
| 1:30 pm–2:15 pm | ASRM Business Meeting |
| 6:00 pm–7:30 pm | ASRM Cocktail Reception |

Tuesday, January 16, 2001

| | |
|-------------------|---|
| 6:30 am–7:00 am | Coffee |
| 6:30 am–12:00 pm | ASRM Registration |
| 7:00 am–8:00 am | Instructional Courses 307–312 |
| 7:00 am–12:30 pm | Posters Open |
| 8:00 am–8:45 am | Panel IV: <i>Perforator Flaps</i> |
| 8:00 am–12:30 pm | Audio Visual Theater |
| 8:45 am–10:36 am | Concurrent Scientific Session D-1 |
| 10:37 am–11:05 am | Break |
| 11:06 am–12:30 pm | Continuation of Concurrent Scientific Session D-1 |
| 8:45 am–10:45 am | Concurrent Scientific Session D-2 |
| 10:45 am–12:30 pm | Poster/Paper Presentations |
| 12:30 pm | Adjourn |
| 12:30 pm–3:00 pm | ASRM Council Meeting |



AAHS 2001 Slate of Candidates

Officers

President (automatic)
Robert T. Buchanan, MD

President-Elect (automatic)
Alan E. Freeland, MD

Vice President
Alan Van Beek, MD

Treasurer-Elect
N. Bradly Meland, MD

Secretary
Ronald Palmer, MD

Sr. Director at Large
Richard E. Brown, MD

Jr. Director at Large
Mark Baratz, MD

Affiliate Director
**Lynn Bassini, MA, OTR,
CHT**

Historian
Nicholas Vedder, MD

Committee Nominations

Nominating Committee
**Keith Brandt, MD
Daniel Nagle, MD**

Affiliate Sub-Committee of
Nominating Committee
Christine Novak, MS, PT

HAND THERAPY PROFILE

Cynthia Cooper, MFA, MA, OTR/L, CHT

Personal: I grew up in Ohio, and lived there through the time I received my fine arts degrees. I retrained in occupational therapy in southern California, and lived and worked there for sixteen years. In the early 1990's, my husband and I moved to Phoenix, AZ. My husband collaborates with me on writing projects, so we get to work together on my professional activities. I enjoy reading, movies, travel, and hiking.



**CYNTHIA COOPER, MFA, MA,
OTR/L, CHT**

Education: I received a BFA in Painting from Kent State University in 1974, and an MFA in Painting from the University of Cincinnati in 1976. My OTR and MA, OTR degrees are from the University of Southern California (1979) and (1981). I received certification in hand therapy in 1991.

Employer: I am the out-patient team leader at the Mayo Clinic Hospital in Phoenix, Arizona, and an Assistant Professor of Physical Medicine and Rehabilitation at the Mayo Medical School, Rochester, Minnesota. At the Mayo Clinic Hospital hand therapy program, we see a wide variety of diag-

noses including trauma, elective reconstructive procedures, and soft tissue diagnoses. A large proportion of the patient population is elderly.

AAHS Involvement: I have been a member of AAHS since about 1981, when the therapist membership numbers were much smaller. I have helped encourage new members, and had the opportunity to participate in the hand therapist conference at the annual meeting in Phoenix in 1998 and to present a poster at AAHS in Hawaii in 1999.

Best Part of My Job: I feel very fortunate to work for an organization where the patient needs come first, there is strong support for ongoing learning and academic activity, and physician-therapist communication and teamwork are valued. These features, along with talented and caring colleagues, allow for treatment that reflects input from the patient and team. When a patient achieves his or her functional goals, it is very rewarding.

Major Accomplishments: Writing articles and chapters on hand therapy, presenting at various conferences, and learning from these experiences while saving time for personal relationships.

Clinical Specialties: Hand therapy considerations for elderly patients, Complex Regional Pain Syndrome, Essential Tremor, Teaching hand therapy basics.

Greatest Challenge: Remembering to listen to patients and letting them lead or participate in their care whenever possible and appropriate, and remembering that a patient's story that at first seems trivial may lead to very personal and important therapy goals or treatment.

Three Words That Describe Me: Reliable, industrious, and curious.

Tackling Arthritis

Seminar Description

The purpose of this one-day seminar is to discuss current concepts in evaluation and management of arthritis of the hand and wrist. The primary focus will be on rheumatoid arthritis and osteoarthritis. In addition to lecture presentations, case studies and panel discussions will be used to illustrate key concepts.

Course Objectives

After attending this one day seminar, participants will have increased knowledge to:

1. Describe the contemporary medical management of rheumatoid arthritis.
2. Explain the surgeons' intervention for arthritis of the wrist and hand.
3. Discuss the role of hand therapy in the non-surgical and post-surgical intervention of patients with rheumatoid and osteoarthritis of the hand and wrist.
4. Describe the basic concepts of tissue engineering of cartilage.

Faculty

Susan Michlovitz, PT, PhD, CHT,
Course Chair

William F. Blair, MD

Leonard Bodell, MD

Paul Brach, MS, PT, CHT

Forst M. Brown, MD

Gail Groth, MS, OTR/L, CHT

Scott Kozin, MD

Paul LaStayo, PT, PhD, CHT

W.P. Andrew Lee, MD

Margery Lockard PT, PhD

Jeanne Melvin, MS, OTR, FAOTA

Nash Naam, MD

Katherine Scofield, OTR/L, CHT

Matthew Tomaino, MD

AAHS Hand Therapy Sponsored Pre-Conference Seminar

AAHS Annual Meeting, January 10, 2001

Loews Coronado Bay Resort

Rheumatoid Arthritis and Osteoarthritis of the Hand and Wrist: An Update

| | |
|-------------------|--|
| 7:15-8:00 am | Registration and Continental Breakfast |
| 8:00 am | Introduction <i>Susan Michlovitz, PT, PhD, CHT</i> |
| 8:10- 8:45 am | Rheumatoid Arthritis: Update on Pharmacologic Management |
| 8:50- 9:30 am | Synovitis and Tenosynovitis in the Rheumatoid Hand and Wrist <i>Forst Brown, MD</i> <i>Jeanne Melvin, MS, OTR, FAOTA</i> |
| 9:30- 10:00 am | MCP Soft Tissue Reconstruction for Rheumatoid Arthritis <i>William F. Blair, MD</i> <i>Gail Groth, MS, OTR/L, CHT</i> |
| 10: 00- 10:15 am | Coffee Break |
| 10:15-10:45 am | Managing the rheumatoid wrist <i>Leonard Bodell, MD</i> <i>Katherine Scofield, OTR/L, CHT</i> |
| 10:45-11:15 am | Managing the rheumatoid thumb <i>Paul Brach, MS, PT, CHT</i> <i>Matthew Tomaino, MD</i> |
| 11:15 am-12:00 pm | Panel Discussion: Managing the Complex Rheumatoid Hand and Wrist <i>Nash Naam, MD (Moderator)</i> <i>William Blair, MD</i> <i>Leonard Bodell, MD</i> <i>Jeanne Melvin, MS, OTR/L, FAOTA</i> <i>Katherine Scofield, OTR/L</i> |
| 12:00-1:20 pm | Lunch 2000 Vargas trip to Lithuania |
| 1:30-2:00 pm | Exercise and arthritis <i>Scott Kozin, MD</i> <i>Margery Lockard, PT, PhD</i> |
| 2:00-2:30 pm | Tissue engineered cartilage <i>WP Andrew Lee, MD</i> |
| 2:30-3:10 pm | Panel Discussion: Basal joint osteoarthritis: controversies in splinting <i>Paul LaStayo, PT, PhD, CHT (Moderator)</i> <i>Paul Brach, MS, PT, CHT</i> <i>Jeanne Melvin, MS, OTR, FAOTA</i> <i>Matthew Tomaino, MD</i> |
| 3:10-3:25 pm | Break |
| 3:30-4:00 pm | Basal Joint Complex reconstruction <i>Paul Brach, MS, PT, CHT</i> <i>Matthew Tomaino, MD</i> |
| 4:00-4:30 pm | PIP joint osteoarthritis <i>Scott Kozin, MD</i> <i>Margery Lockard, PT, PhD</i> |
| 4:45-5:30 pm | Wine and cheese <i>Participants and faculty</i> |

Cumulative Trauma Disorders

*This discussion focuses on the definition of cumulative trauma, its relationship to the workplace, and the management of the most commonly cited example—carpal tunnel syndrome. It is hosted by **Peter C. Amadio, MD**, Professor of Orthopedic Surgery, Mayo Clinic, Rochester, MN. The other panelists are **Morton Kasdan, MD**, Clinical Professor of Plastic Surgery, University of Louisville, **Susan E. Mackinnon, MD**, Shoenberg Professor of Surgery, Chief of the Division of Plastic and Reconstructive Surgery, Washington University School of Medicine, St. Louis, Missouri, **Peter Nathan, MD**, hand surgeon, who has done extensive research into the etiology of carpal tunnel syndrome at the Portland Hand Surgery and Rehabilitation Center, Portland, OR, and **Christine B. Novak, PT, MS**, Research Assistant Professor, Division of Plastic & Reconstructive Surgery, Washington University School of Medicine, St. Louis, Missouri.*

I THINK AN ABSOLUTE
IS THAT YOU MUST
SEE IN ORDER TO
AVOID IATROGENIC
INJURY.

PETER C. AMADIO, MD

Dr. Amadio: Dr. Nathan, what is your definition of cumulative trauma disorders?

Dr. Nathan: For me the definition of cumulative trauma disorders would be a situation in which there are symptoms and the symptoms are confirmed by a tissue change of some type, for example, nerve or muscle. There must be evidence that there is some activity of the upper extremity that is associated with the symptoms

as well as the underlying disease process. In addition, you must look at the other risk factors in the person's life: the work factors, the personal factors of the individual (height, weight, age, and avocational exercise level are some of the examples), and psychosocial factors. When you put all of these together you can decide that this is CTD.

Dr. Amadio: Can you give an example of a condition that you think could be a CTD?

Dr. Nathan: I think that trigger finger can be a CTD. You mentioned lateral epicondylar pain. Shoulder disorders are another; for instance, in a baseball pitcher, shoulder disease,

more probably than not, is going to be associated with the pitching arm.

Dr. Amadio: Do you think that there are any conditions that are always cumulative trauma disorders?

Dr. Nathan: It's really hard to be so categorical to say that anything is "always". I would say for instance, carpal tunnel syndrome, in the main, is not a cumulative trauma disorder. From my experience and from the research, it is a medical problem. Occasionally carpal tunnel could be work related; for instance, if the patient has a Colles' fracture which occurred on the job and there is a nerve abnormality. You can show then that the carpal tunnel syndrome is related to the trauma that caused the fracture.

You can also get carpal tunnel in a cumulative trauma situation when there is forceful flexion of the wrist over time with repetitive flexion of the fingers. I don't think it occurs very often because most situations do not permit us to grasp well with full flexion of the wrist concurrently with finger flexion. Mechanical force or ballistic impact on the volar aspect of the wrist can certainly impact the median nerve.

Dr. Amadio: Dr. Kasdan, do you have anything to add to Dr. Nathan's characterization of cumulative trauma disorder?

Dr. Kasdan: I really think the terminology is inappropriate. I have seen patients who told me their diagnosis was repetitive strain injury. I

think this is harmful labeling. What do we mean by "repetition", by "cumulative"?

Dr. Amadio: Do you think that repetitive activity can be the cause of any particular musculoskeletal problems?

Dr. Kasdan: I think if you are going to look at only the workplace, I have a problem with that. That is what is being done in the literature. Nobody really pays attention to where people spend most of their life away from the job. I don't like the assumption of causation. I think before we assign a particular activity as the cause of the problem, then we need to know, what is the epidemiology of that activity? Do we have good documentation? Can we predict it, prevent it, and is there a dose relationship?

Dr. Amadio: Dr. Mackinnon, what is your definition of cumulative trauma and what would you consider to be examples of disorders, if any, that could be caused by repetitive activity?

Dr. Mackinnon: I have moved away from using the term "cumulative trauma disorder" or "repetitive strain injuries". I call it "work related upper extremity musculoskeletal disorder" and emphasize "related", meaning other things besides work can be related. The disorders would include problems such as carpal tunnel syndrome, cubital tunnel syndrome, tennis elbow, thoracic outlet syndrome, trigger finger, etc.

Last night, I was just reading Michael Ondaatje's book, *Anil's Ghost*. On page 77, he says, "Kennedy studying a first millennium mummy of Thebes discovered marked lines on the flexor ligaments of the phalanges and theorized that the man was a scribe, the marks attributed to his constantly holding a stylus". And then he goes on to say, "Ramazzini in his treatise on the diseases of tradesman had begun it all, talking of metal poisoning among painters. Later the Englishman, Thackran spoke of pelvic deformities among weavers who sat for hours at their looms ("Weaver's bottom" Kennedy noted, may have led to Bottom, the weaver, in *A Mid Summer Night's Dream*). Comparisons were made of similar anatomical ailments between javelin throwers among Neolithic Saharans of the Niger and modern gold professionals. These were the markers of occupation ...".

I think if we continue to say that nothing is work related, we are really going against the tide of common sense; even the people writing our literature are very aware of work related disorders. I definitely think things can be work related. I do agree with Dr. Kasdan that the terms CTD and RSI are every bit as bad as RSD.

Dr. Amadio: Ms. Novak, do you have anything to add to the definitions or comments regarding cumulative trauma disorder?

Ms. Novak: I would be in agreement with the others that we should stay away from the terms CTD and RSI. I think that the term "cumulative trauma disorder" combines patients with many different diagnoses. It is important to make a specific diagnosis and then secondarily to determine if it is work related. As Dr. Nathan said at the beginning, we need to recognize that it is a multifactorial entity including individual factors, psychosocial factors in addition to the physical factors that a person is exposed to both at work and when not at work.

Dr. Amadio: Does everybody feel more comfortable with the term "work related upper extremity disorder" as opposed to "cumulative trauma" or "repetitive strain"?

Dr. Kasdan: Wouldn't "symptoms" be more appropriate than a diagnostic label? The term "disorder" falls into the same trap that the ergonomists are using when they talk about these "disorders" and then they have to define a disorder. It should be the upper extremity symptoms because the patient may indeed not have a diagnosis other than pain. I agree "work related" would be better than "cumulative trauma" because it can include injuries such as a Colles' fracture.

Dr. Amadio: Now we get to the issue of "disorder". Dr. Nathan, you had mentioned initially trying to stick to diagnosable conditions, diseases, injuries that have specific criteria. What about that aspect? Dr. Kasdan just mentioned symptoms. Should we make a distinction between diagnosable conditions, for example, that everyone can agree is carpal tunnel syndrome? There would be appropriate symptoms in the median nerve distribution, electrodiagnostic testing changes and so forth indicating a specific structural disorder where we understand the anatomy, the pathology, and the pathophysiology. On the other hand, there are simply symptoms related to the musculoskeletal system. When we are talking about work related problems, is it important to maintain a distinction between the category of symptoms on the one side and diagnosable diseases on the other?

Dr. Nathan: Absolutely. I feel you must make the distinction. I think today people use the term CTD and often it means that in a particular patient it was nothing more than symptoms or maybe a benign exertional myalgia. This is a symptom-based nonobjective CTD.

On the other hand, the traditional medical model requires that there

are not just symptoms, but also an alteration of some type of tissue. This distinction is very important.

Dr. Amadio: Dr. Mackinnon, what is your take on that response?

Dr. Mackinnon: I am not in total agreement. I think that if you are going to talk about work relatedness and shift from the patient's own insurance over to the workers' compensation insurance, then you need more than symptoms. You need a diagnosis. But before things get to the point where there is a clear diagnosis with abnormal electrical findings, there will be patients with symptoms, physical findings that confirm a working diagnosis and yet have negative electrodiagnostic studies and normal x-ray findings. In those patients, I think it is fair enough to work on the symptoms to try to make patients better by telling them how to prevent carpal tunnel, cubital tunnel, thoracic outlet and muscle strain. However I think when push comes to shove and a lawyer is asking about the cause and effect and who should be paying for this, then I would back off to say that there are a number of symptoms here, but we can't prove that it is caused by work. Therefore, while we can treat and make the patient better, we are not going to lay blame on the job.

Dr. Amadio: Ms. Novak, what about you?

Ms. Novak: I think there needs to be a specific diagnosis. The majority of diagnoses that we make in this group of patients are soft tissue or

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I THINK BEFORE WE ASSIGN A PARTICULAR ACTIVITY AS THE CAUSE OF THE PROBLEM, THEN WE NEED TO KNOW WHAT IS THE EPIDEMIOLOGY OF THAT ACTIVITY?

MORTON KASDAN, MD

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nerve compression types of syndromes and those diagnoses are usually made by a combination of patient symptoms, physical findings and maybe confirmed with some objective tests. I think when you put those together, you can make a specific diagnosis and then secondarily determine if it is related to work.



THERE MUST BE EVIDENCE THAT THERE IS SOME ACTIVITY OF THE UPPER EXTREMITY THAT IS ASSOCIATED WITH THE SYMPTOMS AND THE UNDERLYING DISEASE PROCESS.

PETER NATHAN, MD

Dr. Amadio: Dr. Kasdan, do you have anything to add?

Dr. Kasdan: Yes. I would like to point out one of the problems that I have with this definition. "Disorder", according to Dorland's medical dictionary, is a derangement or an abnormality of function, a morbid physical or mental state. Now, do we really want to say that somebody's symptoms are that?

Dr. Amadio: All right. So separating out diseases from symptoms and staying away from the word "disorder" sounds like where most people are at with this.

It sounds like we are getting close to

some sort of general consensus on the understanding of this problem from a pathological perspective, but not from a sociological one.

Let's turn our attention now towards treatment of some of the conditions that can be considered in this family of work-related problems that certainly occur in people with jobs and certainly occur in the context of people with jobs believing that these problems are related to their work. Specifically I wanted to talk about what strategies you use to keep people working and to get them back to work if they are

not working. I would like to start with carpal tunnel syndrome and Chris Novak.

Ms. Novak: The key to conservative management and to keep people working is patient education. The patients have to understand that these ongoing symptoms, and particularly if their symptoms are increasing, don't necessarily mean that the pathology is getting worse or that it is irreversible. Patient education, to understand the process that is going on and then strategies to avoid the extremes of wrist flexed and wrist extended positions, is critical to successful conservative management. Putting on a splint at night that maintains the wrist in a neutral position will help to decrease the amount of compression on the median nerve over those six or eight hours of sleep. The patient will likely get a better night's sleep and decrease the irritability of the nerve during the day, thus decreasing symptoms.

We don't recommend splints through the day. If you splint in a position of function with the wrist at 30 degrees of extension, you will actually be increasing pressure on the median nerve, whereas if you put the wrist in a neutral position during the day then you have essentially given the patient a stiff wrist in a nonfunctional position

Dr. Amadio: Are there any specific work activities that you would tell people not to do if they have carpal tunnel syndrome?

Ms. Novak: I don't think that there are specific things that I would tell patients not to do. Obviously you would try to avoid the extremes of wrist extension and direct pressure. Jobs would need to be evaluated so as to minimize these positions. In some industries there are certain hand positions and tool modifications that can bring the person into a better position with minor adjustments. I think that it is equally important to look more proximally, at the elbow, the shoulder and the neck, and to see if there are alterations at these levels that would impact on patient symptoms.

Dr. Amadio: Dr. Nathan, how about you?

Dr. Nathan: Let me focus a bit differently. First of all in the work situation if you do have symptoms of CTS you want to be sure there is an abnormality of the nerve and this would include documented nerve conduction changes. If so, I find that in the American worker anything short of surgery is only palliative because you may make the patient comfortable for a week or two if you use splints or not. The nerve essentially is going to get slower over time, or if they go back to work they are going to get a recurrence of the symptoms. So in my situation I really feel that the best way to handle it is to go on to surgery so they can go back to their regular job.

Dr. Amadio: Dr. Mackinnon, how about you? Carpal tunnel syndrome: keeping them at work, getting them back to work.

Dr. Mackinnon: Rarely do we take someone off work. There are so many other hours in the day during which we can modify positions and activities. We spend a lot of time on conservative management and on educating the patient regarding what positions are going to provoke their symptoms and what positions are going to minimize their symptoms.

Just one point about the splinting: if you have carpal tunnel symptoms to begin with and then someone puts you in wrist extension at night, it is almost a guarantee that this will aggravate symptoms. Splinting the patient's wrist in a neutral, not extended, position at night is definitely worth trying. Many of the patients that we see have more than carpal tunnel with other things going on proximally in the extremity. But the patients and the referring physicians attribute all of the symptoms to carpal tunnel syndrome. So I would disagree a little bit with what was said and say that our first knee-jerk reaction is not to go straight to carpal tunnel surgery. We are probably a little slower to recommend carpal tunnel surgery; we put a lot of emphasis on conservatively treating other associated problems.

Dr. Kasdan: I might stress that we make sure the studies are valid and

have considered temperatures, distances, normal values, amplitudes and that one of these little nerve meters has not been used. As you know, all studies, unfortunately, are not equal. Given the diagnosis of carpal tunnel syndrome, I tell the patients I don't think it is work related and if they are willing to go ahead that way, fine. If they want to have a physician to say it is work-related, then they need to find another surgeon. If they are sent in and the company has already accepted that it is a work-related condition and still wants me to take care of them, then I will have a discussion with whomever is responsible at the employer's place. I make sure the patient understands that they are going to go back to modified duty 24 to 48 hours after surgery. If the employer will not provide limited duty, then I usually recommend they find a different physician.

Dr. Nathan: I would say that in my practice I almost never see a person who hasn't been to someone else first for diagnosis of either CTS or

some other condition in the upper extremity. I am not the one who takes them off work; I am not the one who applies a splint or doesn't apply the splint. So I am usually called in for a second opinion or as an independent examiner. At that point with all of this previous care and taking them off work, I feel to prolong going back to work is silly. I think they should be back to work and they should probably go on with the carpal tunnel surgery as quickly as possible so as to achieve this.

Dr. Mackinnon: I'd like to comment on that. I have visited the plants and have seen the jobs that the assembly line workers do. In some of these very large plants, it is not possible to easily give workers modified work to do 24 hours or 48 hours after surgery. In that kind of situation, the employers would rather have the patients go back to work completely recovered with no restrictions. That is of course an oxymoron to say that on one day you are incapable of working and then on the next day you are work-

ing full duty.

I think that you have to work specifically with employers and see what is reasonable for them. Some big companies find it a nightmare to have to figure out modified duty for a couple of months and would rather have the patient return to full duty, no restrictions in six to eight weeks.

Dr. Kasdan: Well, it depends on what the employer provides. Most of the employers in Louisville, and we have some large companies that will work with you and want to get these people back. There has never been a study showing that staying away from work is good for you. To my knowledge every study that has ever come out about this shows that getting back to work is better. You just have to talk to the personnel director; you may have to talk to the supervisor or foreman on the shop floor. But if the largest employer in America, the United States government can get people back to light duty or modified duty, then every-

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one else can work it out. And it's good for the patient. They do better.

Dr. Amadio: Dr. Kasdan, I do want to try to hold you to this now because I would like to know what kinds of work you think are appropriate for someone after carpal tunnel surgery. Specifically, are there differences in the kind of activities that you would

permit, depending upon whether it is their dominant hand or their non-dominant hand?

Dr. Kasdan: They may go into a quality control job. They may go into the office and do some type of data entry on a computer with the hand that is not operated on. But by the same token a hand that has carpal tunnel surgery can hold papers. That hand is not crippled. That hand still has functioning fingers that work very nicely.

Dr. Amadio: So you would let someone, for example, if it were their dominant hand, write or type within a day or two after surgery with that hand?

Dr. Kasdan: Sure.

Dr. Nathan: I published

results some years ago in the *Hand Journal* showing we were able to get people back to modified work usually on an average around four to five days and to regular, unrestricted work something around 17 days. Blue Cross or private patients were able to go back to work or willing, at least, to go back to work much quicker either to modified or to regular work than the worker's comp group.

I think part of the whole crux of getting back to work is preparing them before the surgery. I think you

tell them that they are not going to have a disabling surgical procedure, that they are not going to have an overwhelming amount of pain, and you set the expectations before. It is very crucial that they be involved in therapy. We find therapy with sterile whirlpool and other modalities (range of motion of shoulder, elbow, wrist and digits) and gliding of the nerve and so on will help them, usually with a therapist four to five times after surgery. And it's a constellation of the physician, therapist, patient, and employer.

Dr. Amadio: I think most people would agree that if you have, for example, a white-collar worker with non-dominant hand involvement, probably they can get back to work to their usual job pretty quickly after carpal tunnel surgery. But I am still a bit concerned about the factory worker doing heavy repetitive work on a frequent basis, perhaps lifting 10 or 20 or 30 pounds several dozen times or more per hour and having the dominant hand operated on. When is it appropriate to get that person back to full duty? **Dr. Nathan,** did I understand you correctly that you felt that that kind of a person could get back to work within three weeks after surgery?

Dr. Nathan: Yes. I think that would be the person who is working in heavy industry and who is using his hand for heavy manual activity. I understand that he's going to take longer than the clerical worker or the office administrator. The most common restrictions that we place on them are that we limit the amount of weight and test what they can do in the clinic. We may put restrictions on hours of repetition or hours of work initially.

In Oregon we have a fairly good response from employers to our requirement that they be allowed to work in a modified capacity. If they don't, the burden is on the employer. In that situation, the person doesn't go back to work until I release them to full work, usually in three- to four weeks.

Dr. Mackinnon: Preoperatively, I tell my patients if I were having carpal tunnel surgery I would have it on a Friday and I would see patients on

Monday. I wouldn't operate for about three weeks. If you do a lot of computer keying, you should be able to key an hour a day at a week, four hours a day at four weeks and eight hours a day at eight weeks. There isn't any job I don't think I could return you to at two months, but prior to that, there is going to be some degree of restriction. If I send patients back to physically strenuous jobs with high repetitions at six weeks, I am going to have ten to fifteen percent of those patients back in my office complaining about it.

I really do think that if you are sending somebody back at three weeks to assembly line work, then they are going to be having a lot of discomfort. In my opinion, it is just really not worth it. I think they will finish stronger if they have a reasonable time off. Three weeks, to me, for those heavy-duty jobs isn't reasonable.

Dr. Kasdan: I agree with Dr. Mackinnon, two months. Eight to ten weeks for heavy manual labor. But the thing that everybody is missing is what do you think they are doing at home?

Ms. Novak: I think when you are looking at returning patients to work postoperatively, you would expect that when they are not working they are building up their strength, their endurance so that they will be able to go back to work. In a lot of these jobs, the problem is the lack of control over the work environment. Many patients don't have a lot of control of how much they do and when they can stop and take a break, particularly on an assembly line. It is the amount of control or lack of control, which you have over your job that dictates how much you will have to do.

Dr. Kasdan: Many of them do much heavier things at home.

Dr. Mackinnon: But not for eight hours a day or continuously. Let me emphasize again the element of control in the job. The lack of control in some of these jobs can set you and the patient up for a bad result, if the patient is returned to work too early. Preoperatively, when they are talking to me about



PUTTING ON A SPLINT AT NIGHT THAT MAINTAINS THE WRIST IN A NEUTRAL POSITION WILL HELP TO DECREASE THE AMOUNT OF COMPRESSION ON THE MEDIAN NERVE OVER THOSE SIX OR EIGHT HOURS OF SLEEP.

CHRISTINE B. NOVAK, PT, MS

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returning to work, I say that it has a lot to do with what they actually do but more with how much control they have on the job. If the patient is on an assembly line, there isn't any room for someone that can't keep up with the production rate.

Dr. Kasdan: Dr. Amadio, how about you? How much trouble have you had getting those Minnesota farmers back to work after carpal tunnel release?

Dr. Amadio: Self-employed people tend to go back sooner, but I would agree with Dr. Mackinnon on the reason why: because they can control exactly how much work they do. If they want to work for an hour and 20 minutes or two hours and 37 minutes, they can. And they can ramp it up every day a little bit more, a little bit more, a little bit more, at their own pace. And I think that is probably the best way to do it. But it is impossible, or almost impossible, to get an employer and an employee to agree on an arrangement where the worker comes to work and decides how many hours he is going to put in

that day, what exactly he is going to do from his job description, and when he is going to rotate and when he is not. And I think that is a big difference in the work situation for the employed worker as opposed to the self-employed worker. In the ideal world, where everyone is trusting and mutually respectful and so forth, I think that we should be able to work out the same sort of thing with employed people that we work out with self-employed people and that we try to do ourselves. Basically, do as much as you think you can and maybe just a little bit more, and then take a break, as opposed to someone saying, well, you have to sit there and work all day no matter how you feel.

Dr. Nathan: I think it's more than just the type of job that determines when a person goes back to work. We already said the type of insurance plays a role. We showed previously that for every one centimeter shorter the incision, a one week quicker return to work. Also, I think the use of splints postoperatively

prolongs the recuperation of the patient.

Dr. Amadio: I'm glad you brought that up, Dr. Nathan. After you wrote that paper, I basically stopped splinting. I give patients a splint after their carpal tunnel release for maybe a day or two post-op and then for their comfort after that. I think it has made a dramatic change in the results. Patients are going back much sooner to full activity as a result of resuming activities two or three weeks sooner than they did when we, by force of habit, immobilized the wrists for two or three weeks.

Dr. Kasdan, how long do you continually splint post-op carpal tunnel as opposed to intermittently?

Dr. Kasdan: Depending on how cooperative I think the patient is going to be, anywhere from two to four weeks. I think you can get them off earlier, but we have had so many patients fall or get into automobile accidents. I protect them because I am concerned about the patient.

Dr. Amadio: So when you do a carpal tunnel release then, if I understand you correctly, you will put a splint on and tell the person to leave the splint on continuously for two to four weeks?

Dr. Kasdan: They take it off, when they are going to bathe, but they wear it for two to four weeks, primarily as a protective device.

Ms. Novak: Postoperatively our patients are placed in a bulky dressing with rigid wrist support. The bulky dressing is removed two days after surgery and then the patients are instructed in range of motion



THE PROSPECTIVE RANDOMIZED TRIALS COMPARING OPEN TO ENDOSCOPIC RELEASES IN THE WORKERS' COMPENSATION POPULATION DO NOT SHOW AN EARLIER RETURN TO WORK WITH THE ENDOSCOPIC RELEASE.

SUSAN MACKINNON, MD

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To sign up, look for the Registration Form in the Winter 2001 issue. For more information, call 847-228-9758.

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exercises for hand, wrist, elbow and shoulder. They are given a wrist splint to wear at night. The reason to wear the splint at night is not to protect the surgery but for patient comfort. If the patient goes into the extreme of wrist flexion or wrist extension for prolonged periods of time at night, he or she will wake up with discomfort. This will likely disturb their sleep at night and also give them more discomfort during the day. We continue to splint them at night until the patient has full pain-free range of motion of the wrist. Through the day, their activity level is as tolerated by their discomfort, and initially we restrict them from any heavy lifting.

Dr. Amadio: So what about the length of the incision?

Dr. Nathan: My incisions now run around 2 to 2.5 centimeters.

Dr. Amadio: And you think that the length makes a difference in addition to the duration of the immobilization?

Dr. Nathan: Yes. I really feel no splinting is required. I use a short incision, and a short incision has only come with experience because I used to use longer incisions.

Dr. Amadio: Dr. Kasdan: length of incision?

Dr. Kasdan: Three to four centimeters.

Dr. Amadio: Dr. Mackinnon?

Dr. Mackinnon: My incisions are three to four centimeters. I think that you need to make whatever incision you are comfortable with. There is no room for error in carpal tunnel release. I think that it is fine to use whatever incision you want, but don't injure a cutaneous nerve in the palm and don't injure the median nerve or the ulnar nerve because if you do, there is no easy recovery from that. I think that you need to make the appropriate length of incision to ensure that you see what you are doing and don't cut any vital structures. As the American

population is getting more overweight, I think we need to be cognizant of the idea that a shorter incision is not necessarily better because it creates a deeper, darker hole.

Just one more comment about the obesity issue: because patients are getting more obese, I have been using a lot of forearm tourniquets.

Dr. Amadio: I knew there was a reason why I had stayed with long incisions. Dr. Mackinnon made a strong comment about being able to see things well, so let me just finish up with positions on endoscopic carpal tunnel release.

Dr. Kasdan: I am very much opposed to it. I have seen an awful lot of injuries from it and I have seen very few from the open.

Dr. Nathan: I would agree with Dr. Kasdan.

Dr. Amadio: I must say I feel as Dr. Mackinnon does, that it is very important to see. I know I can see the way I do it, which is an open probably 4 or 5 centimeter incision. And so I am rather hesitant to change. I think that the point that Dr. Mackinnon made, though, that people have particular methods that they find most comfortable is also an important observation. But the other point that she made is, I think, an absolute: that you must see in order to avoid iatrogenic injury. Is there any disagreement with that, since I made a fairly absolute statement?

Dr. Mackinnon: Just one thing to emphasize, the prospective randomized trials comparing open to endoscopic releases in the workers' compensation population do not show an earlier return to work with the endoscopic release. It's not clear to me what, if any advantage there is with an endoscopic release. If an endoscopic release fails, the patient is immediately signed up for an open release. After an open carpal tunnel with an incision of reasonable length with relatively normal studies, patients don't routinely get a potentially unnecessary second operation. But if an endoscopic release doesn't relieve patient symptoms, they are often getting another operation whether they need it or

not.

Dr. Nathan: The nerve slowing really is under the carpal ligament and not in the forearm. Not infrequently there is an incision in the distal forearm and that is unnecessary.

Dr. Amadio: What I would like to do now is sum up.

Ms. Novak: We have been talking a lot about the patients with carpal tunnel syndrome and the difficulties managing those patients, but I think the patients who have only carpal tunnel syndrome, are managed relatively easily. The difficulty comes in managing patients with unrecognized proximal sites of nerve compression or other musculoskeletal disorders. Persistent symptoms in many patients, which are all attributed to compression at the carpal tunnel, are in fact the result of compression at the forearm, elbow, thoracic outlet or cervical spine.

Dr. Mackinnon: I frequently tell patients who are symptomatic, are working and are very upset about causation, that as best we can tell from the literature for carpal tunnel there is a very strong association with the meat packing industry, poultry industry, garment industry, cake decorating, dental hygienists and an exposure to vibration. Otherwise, we really don't have any information for them. If you move past carpal tunnel to other diagnoses like cubital tunnel or heaven forbid thoracic outlet syndrome, we really don't have anything from our medical literature to help them or to help their lawyers determine whether this is work related versus aggravated by work.

Dr. Kasdan: This would not be complete without mentioning the work of Dr. Butler at the University of Minnesota who has pointed out that the data that everybody has collected is badly flawed because of the cost shifting. That people and the doctors make more money and patients have an easier financial burden if doctors say it is related to work. And that is part of the data that is the confounder, the bias that has made the data so invalid. We also need to consider the psychoso-

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cial studies of Dr. Dean Louis at the University of Michigan.

Dr. Amadio: Well, as I started out this discussion, I said that I wanted to try to stay away from the socioeconomic problem. Not because it isn't important—it may well be, as Dr. Kasdan has mentioned, the overriding issue—but because I don't know that the five of us talking over a period of an hour can come to any sensible solution to the problem that is likely to have any effect. However, all of us can make some comment about individual patients. I really appreciate everyone's comments. I think that they were very, very helpful. **H**

American Association for Hand Surgery Calendar

2001

January 10-13, 2001
31st Annual Meeting
Loews Coronado Bay Resort
San Diego, California

July 13-15, 2001
Mid-Year Board of Directors Meeting
The Pines Lodge
Beaver Creek, CO

2002

January 9-12, 2002
32nd Annual Meeting
Westin Caesar Park
Cancun, Mexico

2003

January, 2003
33rd Annual Meeting
Hyatt Regency, Kauai
Kauai, Hawaii

2004

January, 2004
34th Annual Meeting
Palm Springs,
California

2005

January, 2005
35th Annual Meeting
Sanibel Harbor Resort
& Spa
Sanibel Island, Florida

2006

January, 2006
36th Annual Meeting
Tucson, Arizona

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