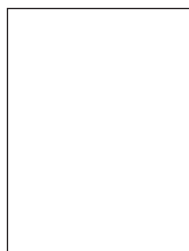


HAND SURGERY

Q U A R T E R L Y



30th Annual Meeting Promises Scientifically Exciting Program



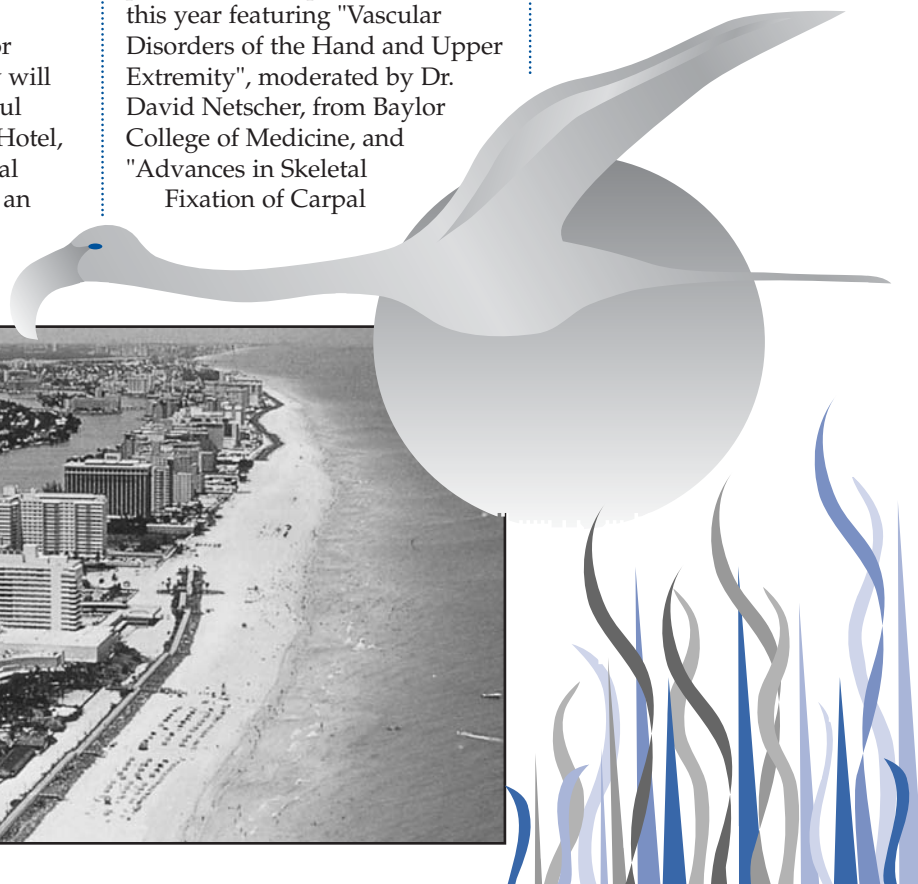
SALEH M. SHENAQ, MD

The 30th Annual Meeting of the American Association for Hand Surgery will be held in the beautiful Loews Miami Beach Hotel, Miami Beach. National scholars will provide an exciting and excellent program, with 68

free papers on pertinent hand-related issues dealing with arthritis, trauma, microsurgery, nerve, tendon, and congenital differences as well as 8 instructional courses offered by recognized experts in the field. Within the free papers are a number of resident/fellow papers, as well as poster presentations. As in recent years, the American Association for Hand Surgery will co-sponsor a program with the American Society for Reconstructive Microsurgery of invited speakers and panel discussions, which will be held on Saturday. We are pleased to have panel discussions this year featuring "Vascular Disorders of the Hand and Upper Extremity", moderated by Dr. David Netscher, from Baylor College of Medicine, and "Advances in Skeletal Fixation of Carpal

and Metacarpal Fractures", moderated Dr. Richard Berger, from Mayo Clinic. On our joint day, Dr. William Pederson, from U.T. San Antonio, will moderate a panel on hand transplantation, and the second panel will be moderated by myself on the newest management of brachial plexus lesions. We hope you can join us for what promises to be a scientifically exciting program with plenty of fun leisure activities for the family.

*Saleh M. Shenaq, MD
Chair, AAHS 2000 Scientific Program*



Who's in Control of American Medicine?

As we approach the turn of the millennium (84 days and counting as of this moment), have you taken a moment to review the status of American medicine? Who is really in control?

Certainly it is not the doctors. They are split into two camps: the first group which has deserted the practice of medicine for the security and anonymity of the administrative office; and the second which has stayed in clinical practice for better or for

worse.

Certainly it is not the regulators. They seem to be playing "catch-up" ball by passing laws, which cover the sorest issues of their constituents. In other words, playing to the next election. As Congress comes to grips with the "Patient's Bill of Rights", the drama of the disintegration of American medicine is being played out on the political stage.

Certainly it is with the insurance industry. Listening to National Public Radio while performing my morning ablutions, I was struck by the profundity of the commentator's remark that, "In the proceeding few days, the halls of Congress had been 'awash' with lobbyists representing the insurance industry". He deemed, in his presentation and style, that he had stumbled on some fundamental truth. Actually, he was just becoming aware of a truth that physicians have known for roughly 35 years. The "deep pockets" of the insur-

ance industry became known during the debates on national health insurance in the 1960's which led to the formation of Blue Cross and Blue Shield to service the Medicare industry. I have it on impeccable authority that the insurance industry had several select operatives sitting on the committee which wrote the final legislation. No wonder that the insurance industry profited significantly both financially and administratively (read that as control) from the Congressional delivery of American medical care to the insurance industry.

In 1999, the efforts of the insurance industry to control the political fate of the "Patient's Bill of Rights", with its undesired provision to allow patients to sue their HMOs (read this insurance company), has precipitated a cash flow into the campaign coffers of Senators and Representative of astronomical proportions. The spending on the next campaign should produce unique and interesting advertising.

To listen to the Republicans, this will open the doors to unfettered litigation. This event has not come to pass in the states where such activity is permitted. The GOP has embraced every calamitous argument that the insurance industry has provided them. It has become so inane that Rep. Ganske (R-IA), a plastic surgeon and a hand surgeon (Member of AAHS) stepped away from the party leadership to follow his conscience. This undoubtedly cost him some votes in the 2000 election and some damage to his campaign coffers (please support his appeals), but he stood up to the insurance industry and said, "this is not right". Sixty-five of his fellow Republican Representatives agreed, voted with the Democratic minority and the House version of the "Patient's Bill of Rights" has now been passed. Whether it will survive the Joint Conference Committee intact is unclear. But all

of us should become knowledgeable about the issues, timing, and actions of this Committee. But, popular political control of Joint Conference Committees and their activities is far more difficult than trying to affect either chamber of Congress.

If the Senate's "watered-down" version of the bill is forwarded, it will be one more victory for the insurance industry in the battle to divide the segments of the health care reimbursement system into portions that they control, e.g. the HMOs, the PMS', the "for profit" hospitals, etc. Thus the "dis-integration" of American medicine. Passage of the bill in the House version will be the first step in replacing the regulatory, legislative, and judicial controls that the insurance shed when they successfully squashed the Clinton Health Care Proposal of 1994. We all remember that scenario!

Keep abreast of this issue, it may critically affect your future and the future of American medicine. **H**

JAMES G. HOEHN, MD

Hand Surgery
Quarterly

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2000

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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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Cooperation Key to Past Year Highs and Future Events

As the year, decade, century and millennium all draw to a close, it is time to look back at a rather tumultuous year and see how far we have come. 2000 marks the 30th anniversary of our Hand Association, a time for celebration and reflection.

The year began with a fantastic Annual Meeting in Hawaii shared with the ASRM. The idyllic resort provided a unique setting for education, fellowship, and relaxation. I personally will long remember watching whales breach just off shore as I sipped Kona coffee and perused the meeting abstracts. Despite the distance, Hawaii was among the best attended annual meetings and achieved a modest profit.

This meeting also marked a transition from our relationship with the ASPRS' Associated Management Services (AMS) to our new management—the Illinois State Medical Society, Division of Specialty Services (DSS), headed once again by Laura Downs Leeper, CAE. Some of you may have noticed that rock on her finger during the past year. We all wish Laura and Mary Jo Harrold, CMP the best in this new organization, and appreciate their management, meeting planning skills and the loyalty they have shown to the AAHS over the years.

Without going into great detail about the turmoil in AMS that led to several organizations leaving

their management, including ASRM, suffice it to say that we parted amicably and in a financially strong position. AMS' decision to focus its activities, in my opinion, was a reflection of the difficulties that large umbrella organizations face in meeting the needs of more focused subspecialty societies. The end result of these events, however, was to bring together sister societies whose interests are better aligned. ASRM, which had experienced similar difficulties with AMS, agreed to work with AAHS to identify a new management company that would meet both our goals and needs. Leadership from both organizations formed a search committee, and then interviewed four highly competitive association management firms before choosing ISMS to oversee our combined activities. The synergy between Hand and Microsurgery that has been evident over the past several years as we have held meeting together, continues with our management organization.

Most recently, the American Society for Peripheral Nerve has requested to meet conjointly with AAHS and ASRM at our 2001 meet-

ing in San Diego. Since many of our memberships overlap, it makes great economic and scientific sense to do so. All three organizations have independently come to the same conclusion: The clinical problems we solve are neuro-musculoskeletal, defining an area of specialization that crosses multiple primary specialties. At each of our separate meetings, we discuss many of the same issues. Separate meetings require additional time away from family and practice. Combined meetings allow for a selection of closely related topics in a time and cost efficient format. Our respective Chairs of Programs and Time and Place Committees are enthused to organize a meaningful program that will meet each organization's needs and benefit all.

As we look forward to our next meeting in South Beach, Miami, much discussion will focus on how we can better serve you, our members. Your participation, suggestions and attendance are vital for keeping AAHS responsive to your needs. It has been an honor to serve as your President. **H**

WILLIAM M. SWARTZ, MD, FACS

AAHS 2000 Slate of Candidates



Officers

President (automatic)
 President-Elect (automatic)
 Vice President
 Treasurer
 Historian
 Senior Director
 Junior Director

William F. Blair, MD
Robert T. Buchanan, MD
Alan Freeland, MD
Richard A. Berger, MD
Nash Naam, MD
A. Lee Osterman, MD
William Lineaweaver, MD

Committee Chairmen

Education Committee Chair
 Time & Place Committee Chair
 Nominating Committee

W.P. Andrew Lee, MD
N. Bradley Meland, MD
Nicholas Vedder, MD
Brian Adams, MD

Hand Surgery Quarterly

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Co-Chairs Peter Amadio, MD (left) and Dean Louis, MD at the opening of the Scientific Session.

First Joint AAHS-ASSH Education Course a Great Success

Between October 1 and October 3, 1999, the Oak Brook Hills Resort, Oak Brook Illinois, was the place to be for hand surgeons and hand therapists. That was where the course, "Occupational Injuries: Cumulative Trauma Disorders in the Upper Extremity", took place before a capacity crowd of over 200 attendees. The attendees of the first combined AAHS-ASSH continuing education course came early and stayed late to discuss cutting edge issues of physiology, epidemiology, biomechanics, prevention, clinical care and return to work with 16 faculty recruited from across the nation. Course

chairs Peter Amadio MD, for AAHS, and Dean Louis MD, for ASSH, assembled a talented faculty whose differences of opinion kept the sessions stimulating without being adversarial. Of course, as Past Presidents of AAHS and ASSH respectively, Amadio and Louis have had a fair bit of experience in keeping discussions on track!

Small group sessions made it possible for everyone to have their say, and gave the attendees the opportunity to discuss their own difficult cases with the faculty. Hand therapists Chris NovakPT, MS, and Colette Jewell OTR, CHT, kept the surgeons honest, and ensured that the special AAHS therapist-surgeon relationship was preserved in this combined course

with ASSH. The highlight of the meeting was undoubtedly the debate on the proposed OSHA ergonomics regulations, with Peter Amadio speaking in favor and Michael Vender speaking against. Who won? Well, if you weren't there you'll have to ask someone who was! Based on the early feedback, though, you may yet have a chance to see for yourself. As the meeting drew to a close Sunday at noon, many attendees (and how many meetings still have 'many attendees' crowding around the podium after the last talk?) were asking when the course would be held again. Don't be surprised to see this on the meeting calendar again in 2001! **H**

PROFILE



Historian Nash H. Naam, MD

Dr. Nash H. Naam is a Clinical Professor of Hand Surgery at the Department of Plastic and Reconstructive Surgery of Southern Illinois University Medical School. He graduated from Ain Shams University in Cairo, Egypt. He had orthopedic training at Ain Shams University in Cairo, then general

surgery training at St. Louis University followed by a hand surgery fellowship at the University of Colorado. He has been in private practice since 1983, and he is the director of the Southern Illinois Hand Center. Dr. Naam has authored several scientific publications and book chapters. He currently serves as the chairman of the Ethics Committee for the AAHS. He also serves as a delegate to the International Federation representing the Eastern Mediterranean Hand Society. Dr. Naam has a great interest in promoting hand surgery in the developing countries. Through his volunteer efforts, he helped to establish the first hand surgery unit in Cairo, Egypt. This unit is now functioning as an incubator for a new generation of hand surgeons in Egypt. Dr. Naam also serves as an Associate Editor of the *Journal of the Egyptian Orthopedic Association*. **H**

30TH ANNUAL MEETING

LOEWS MIAMI BEACH HOTEL
SOUTH BEACH, FLORIDA
JANUARY 5-8, 2000



AAHS Program at a Glance

Wednesday, January 5, 2000

6:30 am–5:00 pm	Speaker Ready Room
7:00–8:00 am	Hand Therapy Pre-Conference Registration and Continental Breakfast
8:00 am–5:00 pm	Hand Therapy Pre-Conference Seminar: "Fracture Management: Evidence Based- Surgical and Therapy Practice"
10:00 am–5:00 pm	Poster Set Up
12:00–5:00 pm	AAHS Annual Meeting Registration
12:30–1:30 pm	Hand Therapy Lunch
5:00–10:00 pm	AAHS Board of Directors Meeting

Thursday, January 6, 2000

6:30 am–5:00 pm	Audio Visual Theater
6:30 am–5:00 pm	Speaker Ready Room
6:30–11:00 am	AAHS Registration
7:00–7:30 am	Continental Breakfast
7:00 am–5:00 pm	Posters
7:00–7:03 am	President's Welcome <i>William Swartz, MD</i>
7:03–7:08 am	Welcome <i>William P. Cooney, MD</i> ASSH President
7:08–7:10 am	Welcome <i>Saleh Shenaq, MD,</i> 2000 Program Chair
7:10–7:30 am	Report from the 1999 Vargas Award Winner
7:30–9:30 am	Concurrent Paper Session A-1
7:30–9:30 am	Concurrent Paper Session A-2
8:00 am–5:00 pm	Exhibit Set Up
9:30–10:30 am	Panel I "Vascular Disorders of the Hand & Upper Extremity"
10:30–11:00 am	Presidential Invited Lecturer <i>Nancy Dickey, MD</i>

11:00 am–4:00 pm	Adjourn
3:30–5:00 pm	AAHS Registration
4:00–5:00 pm	Instructional Courses
5:15–6:00 pm	Paper Session B

Friday, January 7, 2000

6:30 am–5:00 pm	Audio Visual Theater
6:30 am–5:00 pm	Speaker Ready Room
6:30 am–12:00 pm	AAHS Registration
6:30–7:00 am	Continental Breakfast
7:00 am–3:00 pm	Posters
7:00–10:00 am	Paper Session C
8:00 am–2:00 pm	Exhibit Hall
10:00–11:00 am	Panel II "Advances in Skeletal Fixation of Carpal and Metacarpal Fracture"
11:00–11:30 am	Keynote Speaker: <i>Frank E. Jones, MD</i>
11:30 am–1:00 pm	Awards Luncheon
1:00–1:30 pm	AAHS Business Meeting
2:00–3:30 pm	AAHS Board of Directors Meeting
3:30–5:00 pm	ASRM Outgoing Council Meeting
7:00–9:00 pm	AAHS Welcome Reception

AAHS/ASRM Joint Day Program-at-a-Glance

Saturday, January 8, 2000

6:30 am–5:00 pm	Speaker Ready Room
6:30–7:00 am	Continental Breakfast
7:00 am–4:00 pm	Registration
7:00–8:00 am	Instructional Courses
7:00 am–12:00 pm	Posters
8:00 am–2:00 pm	Exhibit Hall
8:05–8:15 am	Presidents' Welcome <i>William Swartz, MD</i> <i>Daniel Nagle, MD</i>
8:15–9:15 am	Joint Panel I "Management of Brachial Plexus Lesions"
9:15–9:45 am	Presidents' Lecturer <i>Alfred Berger, MD</i>
9:45–10:00 am	Break
10:00–11:00 am	Joint Panel II "Hand Transplantation"
11:00 am–12:15 pm	Adjourn
12:15 pm	Golf Tournament - Depart Hotel
12:00–5:00 pm	AAHS Poster Tear Down ASRM Poster Set Up
7:00–11:00 pm	AAHS/ASRM SoBe Soiree

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2000 Bylaws Change Proposals

This year a number of changes to the Bylaws are proposed. These changes have been recommended by the Board of Directors in order to better reflect the Association's goals, improve operations, and allow the organization to continue to thrive into the future. These changes have been refined by the Bylaws Committee, approved by the Executive Committee, and will be

presented to the general membership at the January 2000 Business Meeting for approval. The following changes are proposed:

In order to encourage new membership and allow active participation in the organization at early levels of training, the Board wishes to develop the category of "Candidate Membership." This is reflected in the revised Article I, Section 6. This category is designed to be inclusive of both prospective active and affiliate members. It is hoped that this new category of membership will add new vitality to the organization and encourage later active membership. Another change in Article I is to change the title of "Corresponding" membership to "International" membership.

Because of the vital nature of the office of Treasurer to the ongoing viability of the association, the Board of Directors wishes to develop the position of "Treasurer-Elect" so that the new Treasurer does not find him or herself tossed, unprepared, into the middle of a very complex financial situation. This has been done in Article IV, Section 3F (and modified 3E). The Treasurer-Elect will be elected one year prior to the expiration of the Treasurer's term, then automatically assume the position of Treasurer the following year.

As a result of recent bylaws changes enacted, the standing committee chairs no longer attend nor vote at Board of Directors meetings. Because of this change, it is inconsistent to have these positions continue

AAHS Proposed Bylaws Changes

~~Strikethrough~~ denotes a deletion, underline denotes an addition

SECTION 3-CLASSES OF MEMBERSHIP

There shall be seven (7) classes of membership as follows:

- | | |
|---------------------------------------|---------------------------------|
| A. Active | E. Honorary Emeritus |
| B. Affiliate | F. Inactive Honorary |
| C. Corresponding Candidate | G. Retired Inactive |
| D. Emeritus International | H. Retired |

SECTION 5-AFFILIATE MEMBERSHIP

B. Voting Privileges

Affiliate members may not vote at general business meetings of the Association with the exception of voting for the Vice Chair of the Committee for Hand Therapy and the one (1) affiliate member of the Affiliate Subcommittee of the Nominating Committee, and Affiliate members may not hold office other than Affiliate Director, but may serve on committees and may exercise voting privileges concerning committee business.

SECTION 6-CANDIDATE MEMBERSHIP

A. Membership Criteria

Candidate membership shall be limited to surgeons, or other individuals of the medical profession, basic sciences or allied services who are either in training or within three (3) years of completion of training in an accredited training program in the United States or Canada and whose interests and contributions are related to the advancement of hand surgery. Candidate Membership is limited to three (3) years following the completion of training at which time candidate members must convert to active or affiliate membership.

B. Voting Privileges

Candidate members may not vote at general business meetings of the Association and may not hold office, but may serve on committees and may exercise voting privileges concerning committee business.

C. Fees

Candidate members will pay entrance fees, annual dues, registration fees at the Annual Meeting, and other assessments at a rate determined by the Board of Directors.

SECTION 6 ~~7~~ CORRESPONDING INTERNATIONAL MEMBERSHIP

SECTION ~~12~~ 13-RESIGNATION

Any member may resign from the Association on due notification to the Board of Directors. ~~The membership certificate issued by the Association must be returned.~~ All prior dues and fees should be paid in full and are not subject to refund.

ARTICLE IV-OFFICERS

SECTION 1-OFFICERS

The Officers of the Association shall consist of the President, President-Elect, Vice-President, Secretary, Treasurer, Treasurer-Elect, Historian, and Parliamentarian. They shall serve on the Executive Committee and on the Board of Directors.

E. Treasurer

1. Duties - The Treasurer shall have custody of all Association funds and shall collect all dues and monies due the Association from any source. He/she shall disburse all funds in accordance with budgets or as authorized by the Board of Directors. He/she shall be responsible for the safekeeping of all financial records, securities and other properties of the

to be elected positions. For this reason, the Board of Directors proposes that these positions become appointed positions, as in most other organizations, with the exception of the Finance Committee Chair, which would remain an elected position. In this way, the President, rather than the Past President (who chairs the Nominating Committee) would be more involved in filling these positions. This seems appropriate, since the incoming President would be the person more directly involved with these committee chairs. These changes are reflected in the revised Article VIII. Also changed in Article VIII is changing the titles of the Jr. and Sr. Co-Chairs of the Committee for Hand Therapy to Vice Chair and Chair, respectively.

Because of the importance of the Hand Therapists' involvement and contributions to the Association, the Board of Directors feel that it is important to acknowledge the role of the affiliate membership in a number of ways, including pursuing membership of the AAHS in the International Federation of Societies for Hand Therapy (IFSHT). The first step in this process would be to have the current associate member representation on the Board of Directors, the Senior Co-Chair (Chair) of the Committee for Hand Therapy, become an elected position, rather than an appointed position. To accomplish this, the Nominating Committee would become two subcommittees, as is done for the Membership Committee, with an

Active and an Affiliate Subcommittee. The Vice Chair of the Committee for Hand Therapy would be nominated by the Affiliate Subcommittee, composed of the President-Elect, the Immediate Past Chair of the Committee for Hand Therapy, and an affiliate member nominated from the floor and elected at the Annual Meeting. The Vice Chair of the Committee for Hand Therapy would then be nominated by this subcommittee and elected by the affiliate membership at the Annual Meeting. These changes are reflected in the revision Articles V, VII, and VIII. **H**

*Nicholas B. Vedder, MD
Parliamentarian*

American Association for Hand Surgery, and shall deposit all such funds in the name of the Association in such bank or depository as shall be incurred in behalf of the Association without previous approval of the President and/or Secretary. The Treasurer shall be bonded in an amount determined by the Board of Directors. He/she shall perform such other duties as may be required by the Board of Directors. During his/her last year of office, the Treasurer will prepare the Treasurer Elect to assume the office of Treasurer.

2. Term of Office - The Treasurer's term of office is three (3) years.

~~Special Note: The Association funds should be allocated to reserves, equivalent to 150% of the projected operating and activity expenses for the projected budget year. If reserves fall below this level, then money could be budgeted toward reestablishing the reserves to their proper goal within a five year time frame.~~

F. Treasurer-Elect

1. Duties - The Treasurer-Elect shall perform such duties as the Treasurer may assign. He/she shall attend all meetings of the Board of Directors, including meetings of the Executive Committee and shall be a member of the Finance Committee. The Treasurer Elect may not vote at meetings of the Board of Directors in his/her role as Treasurer Elect, but may exercise voting privileges concerning Finance Committee business. A current member of the Board of Directors or Chair of the Finance Committee may serve as Treasurer Elect concurrently.

2. Term of Office - The Treasurer-Elect shall automatically succeed to the Treasurer upon expiration of the Treasurer's term. The Treasurer-Elect's term of office is one (1) year.

ARTICLE V-BOARD OF DIRECTORS

SECTION 1-COMPOSITION

The Board of Directors shall consist of the seven (7) officers ~~(and the Treasurer-Elect during his/her year of tenure), the two (2) immediate past president Past Presidents, the four (4) directors-at-large Directors-at-Large, and the Senior Co-Chair Chair and Vice Chairs of the Committee for Hand Therapy, who will act as Affiliate Directors.~~

SECTION 7-TERMS OF OFFICE

The terms of office of the four (4) Directors-at-Large are two (2) years, the terms of office for the Chair and Vice Chairs of the Committee for Hand Therapy are one (1) year ~~Standing Committee Chairs are prescribed in Article VIII, and the terms of office for the Officers are prescribed in Article IV.~~

SECTION 8-ELECTION ROTATION

~~The Vice-President, the Historian, the Vice Chair of the Committee for Hand Therapy, and two Directors-at-Large shall be elected every year. Of the two directors, one shall be an active member for more than (7) seven years and the other, for not more than seven years. The Secretary, and the Membership Committee Chair, and the Finance Committee Chair will be elected every three (3) years. will be elected in the same year. The Treasurer The Treasurer-Elect and the Ethics Committee Chair will be elected in the same year the final year of the Treasurer's term. The Time and Place Committee Chair and the Education Committee Chair will be elected in the same year.~~

continued on page 8

AAHS Proposed Bylaws Changes

continued from page 7

ARTICLE VII-NOMINATIONS AND ELECTIONS

SECTION I-NOMINATIONS

Only active members in good standing are eligible for nominations and election to office or Board positions in the Association.

The Active Subcommittee of the Nominating Committee shall prepare and submit to the Secretary each year a single slate of one nominee for each position (officer, ~~standing committee chair~~ Finance Committee Chair, nominating committee member, and director-at-large) to be filled by election that year. The Affiliate Subcommittee of the Nominating Committee shall prepare and submit to the Secretary each year a single slate of one nominee for Vice Chair of the Committee for Hand Therapy. The Secretary shall distribute the Active Subcommittee slate to all active members and the Affiliate Subcommittee slate to all affiliate members at least sixty (60) days prior to the Annual Business Meeting. ~~Additional nominations may be made by active members from the floor.~~

In addition, two (2) active members of the Active Subcommittee of the Nominating Committee shall be nominated from the floor by active members at the Annual Business Meeting. One (1) affiliate member of the Affiliate Subcommittee of the Nominating Committee shall be nominated from the floor by affiliate members at the Annual Business Meeting.

Individuals nominated by the Nominating Committee must provide prior written consent to the Secretary. Those nominated from the floor may consent from the floor.

SECTION 2-ELECTIONS

A. Officers

All officers except the President, the President-Elect, Treasurer, and the Parliamentarian shall be elected by a simple majority of voting members present at the Annual Business Meeting. The President ~~and~~ President-Elect, and Treasurer shall succeed to their positions automatically. The Parliamentarian is appointed by the President.

B. Directors

The Directors-at-Large and Chairs of the Standing Finance Committees ~~(except the Program Committee Chair and Co-Chairs of the Committee for Hand Therapy)~~ shall be elected by a simple majority of voting members present at the Annual Business Meeting.

~~The Program Committee Chair succeeds to the position from the position of First Assistant Chair, who succeeds to that position from the position of the Second Assistant Chair, a position appointed by the Vice President.~~

The Sr. Co-Chair of the Committee for Hand Therapy succeeds to the position from the position of Jr. Co-Vice Chair. The Jr. Co-Vice Chair is elected by a simple majority of affiliate members present at the Annual Business Meeting. ~~recommended by~~

~~the Sr. Co-Chair in consultation with the President Elect and approved by the Board of Directors.~~

C. Nominating Committee Members

The two (2) ~~individuals~~ active members nominated by the Active Subcommittee of the Nominating Committee and the two (2) ~~individuals~~ active members nominated from the floor at the Annual Business Meeting shall be elected by a simple majority of voting active members present at the Annual Business Meeting. The one (1) affiliate member of the Affiliate Subcommittee of the Nominating Committee nominated from the floor at the Annual Business Meeting shall be elected by a simple majority of affiliate members present at the Annual Business Meeting.

ARTICLE VIII-COMMITTEES

SECTION 1-STANDING COMMITTEES

There shall be the following Standing Committees of the Association:

- | | | |
|-----------------|---------------|---------------------------------|
| A. Membership | H. | Ethics |
| B. Nominating | I. | Time & Place |
| C. Program | J. | Archives |
| D. Bylaws | K. | Marketing |
| E. Education | L. | Research Grants |
| F. Finance | A. | Membership Committee |
| G. Hand Therapy | | |

A. Membership Committee

1. Composition - The Membership Committee shall consist of two (2) subcommittees, an Active Subcommittee to review all active and non-therapist-affiliate applications and a Therapist Subcommittee to review all therapist applications. The Active Subcommittee shall consist of ~~the elected~~ an appointed chair and at least three (3) appointed active members. The Therapist Subcommittee shall consist of three (3) appointed therapist members. The person in the third year of their appointment shall serve as Chairperson of the Therapist Subcommittee.

2. Term of Membership - The Chairperson of the Active Subcommittee shall serve a three (3) year term. Each member of the Active Subcommittee shall serve a three (3) year term. Each member of the Therapist Subcommittee shall serve a three (3) year term. Terms shall be staggered, with the President appointing one (1) new active member and one (1) new therapist member each year and a Chairperson of the Active Subcommittee every three (3) years.

B. Nominating Committee

1. Composition - The Nominating Committee shall consist of two (2) subcommittees, an Active Subcommittee and an Affiliate Subcommittee. The Active Subcommittee of the Nominating Committee shall consist of the Immediate Past President, who shall serve as Chair, two (2) active members nominated by the current year's Nominating Committee and elected at the Annual Business Meeting, and two (2) active members nominated from the floor and elected at the Annual Business Meeting. The Affiliate Subcommittee of the Nominating Committee shall consist of the President Elect, the Immediate Past Chair of the Committee for Hand Therapy and one (1) affiliate member nominated from the floor and elected at the Annual Business Meeting. Members of the Committee

may be nominated for an elected position, but must then immediately resign from the Committee.

2. Term of Membership - The term of membership in this committee is one (1) year.

3. Duties - The Active Subcommittee of the Nominating Committee shall prepare and submit to the Secretary each year a slate of one nominee for each position (officer, ~~standing committee chair~~, Finance Committee Chair, nominating committee member, and director-at-large) to be filled by election that year. The Affiliate Subcommittee of the Nominating Committee shall prepare and submit to the Secretary each year a slate of one nominee for the position of Vice Chair of the Committee for Hand Therapy.

C. Program Committee

1. Composition - The Program Committee shall consist of the Chair; the Immediate Past Program Chair, who shall serve in an ex-officio capacity; the First Assistant Chair; the Second Assistant Chair; two (2) appointed active members; and the ~~Sr. Co-Chair~~ of the Committee for Hand Therapy.

2. Term of Membership - The Program Committee Chair succeeds to the position from the position of First Assistant Chair, who succeeds to that position from the position of the Second Assistant Chair. The Second Assistant Chair shall be appointed by the Vice-President. The Second Assistant Chair shall rotate through the positions of First Assistant Chair, Chair, and Immediate Past Chair. The term for each of these positions is one (1) year. Each of the other two (2) active members shall serve a three (3) year term. These terms shall be staggered, with the President appointing one (1) new active member each year a slot is open. The term for the ~~Sr. Co-Chair~~ Chair of the Committee for Hand Therapy will be one (1) year.

E. Education Committee

1. Composition - The Education Committee shall consist of ~~the elected an appointed~~ chair, three (3) appointed active members, and the ~~Sr. Co-Chair and Jr. Co-Chair~~ Chair and Vice Chair of the Committee for Hand Therapy.

2. Term of Membership - The Chairperson shall serve a three (3) year term. Each active member shall serve a three (3) year term. The active members' terms shall be staggered, with the President appointing one (1) active member each year and a Chairperson every three (3) years. Each Therapist member shall serve a two (2) year term, the first year as ~~Jr. Co-Vice Chair~~ and the Second ~~as Sr. Co-Chair~~.

F. Finance Committee

1. Composition - The Finance Committee shall consist of the elected chair, the Treasurer, the Treasurer-Elect, the President, the President-Elect, and the Immediate Past President.

Special Note: The Association funds should be allocated to reserves, equivalent to 150% of the projected operating and activity expenses for the projected budget year. If reserves fall below this level, then money could be budgeted toward reestablishing the reserves to their proper goal within a five year time frame.

G. Committee for Hand Therapy

1. Composition - The Committee for Hand Therapy shall consist of three (3) ~~appointed~~ elected therapist members.

2. Term of Membership - Each member shall serve a three (3) year term. Members shall serve their first year in the position of ~~Jr. Co-Vice Chair~~, their second year in the position of ~~Sr. Co-Chair~~, and their third year in the position of Immediate Past Chair and Liaison to Therapist Organizations. The Chair of the Committee for Hand Therapy succeeds to the position from the position of Vice Chair who is elected annually. Each year, the Sr. Co-Chair, in consultation with the President Elect, will recommend to the Board of Directors for approval an individual for the position of Jr. Co-Chair.

3. Duties - The purpose of the Committee shall be to develop educational opportunities for the therapist and other members, disseminate information to the therapist members, represent the therapist membership's viewpoint to the Board of Directors, encourage continued growth of the therapist membership, foster the exchange of information between professional organizations, and evaluate questions of medical ethics and professional activities related to therapist members and brought to the Board of Directors at the request of a member, a committee chair, or a member of the Board. The Chair and Vice Chair of the Committee for Hand Therapy will both both be voting members of the Board of Directors as Affiliate Directors.

H. Ethics Committee

1. Composition - The Ethics Committee shall consist of ~~the elected~~ the appointed chair and three (3) appointed active members.

2. Term of Membership - The Chairperson shall serve a three (3) year term. Each member shall serve a three (3) year term. Members' terms will be staggered, with the President appointing one (1) new member each year and a Chairperson every three (3) years.

I. Time and Place Committee

1. Composition - The Time and Place Committee shall consist of ~~the elected~~ the appointed chair and three (3) appointed active members.

2. Term of Membership - The Chairperson shall serve a three (3) year term. Each member shall serve a three (3) year term. Members' terms will be staggered, with the President appointing one (1) new member each year and a Chairperson every three (3) years.

K. Marketing Committee

1. Composition - The Marketing Committee shall consist of ~~the elected~~ the appointed chair, three appointed active members and the chair of the Membership Committee who will function as an ex-officio member.

2. Term of Membership - The Chairperson of the Marketing Committee shall serve a one (1) year term. Each member of the Marketing Committee shall serve a three (3) year term with the terms staggered such that one new member and a Chairperson is appointed by the ~~president~~ President each year.

Osteoarthritis

Patients with osteoarthritis frequently consult hand surgeons. Management of this disorder is the topic of this round table discussion.



MY INDICATIONS FOR PIP JOINT REPLACEMENT ARE PAIN AT THE PROXIMAL INTERPHALANGEAL JOINT, SIGNIFICANT ANGULAR DEFORMITY, PARTICULARLY IN THE ULNAR THREE DIGITS, OR A LIMITED NON-FUNCTIONAL RANGE OF MOTION.

A. LEE OSTERMAN, MD

The moderator is **A. Lee Osterman, MD**, Professor, Hand and Orthopaedic Surgery, Thomas Jefferson University, and The Philadelphia Hand Center, Philadelphia, PA. He is joined by **Mark Cohen, MD**, Associate Professor, Director, Hand and Elbow Program, Dept. of Orthopaedic Surgery, Rush-Presbyterian-St. Lukes Medical Center, Chicago, IL, **Lon Howard, MD, FAOS**, Private Practice, Littleton Orthopaedics, P.C., Littleton, NH, and **Marge Tull, PT, CHT**, Clinical Specialist, Moss Hand Center, Philadelphia, PA.

Dr. Osterman:

Welcome everybody. Osteoarthritis is one of the most common diseases that affects hands. What I'd like to do is to look at its effect, particularly as it involves the interphalangeal joints. Classifying osteoarthritis in the hand: first, there's the most common "nodal" osteoarthritis that involves mainly the DIP joints. The second type is multiple joint involvement of not only the DIP joints, but the PIP joints and the thumb car-

pometacarpal joint. The third pattern is erosive osteoarthritis. Dr. Cohen, can you talk about what the signs and symptoms of interphalangeal osteoarthritis are?

Dr. Cohen: The typical presentation is a middle age or older adult woman who complains of aching pain, morning stiffness and often cosmetic deformities, including

enlargement and angular deformities of the joints. She often reports a similar pattern of arthritis in her mother.

Dr. Osterman: How would you describe the stiffness compared to that in rheumatoid arthritis?

Dr. Cohen: Stiffness is most pronounced in the morning and is often brief, improving with use over 30-60 minutes.

Dr. Osterman: How would you describe the X-rays finding of osteoarthritis as compared to rheumatoid arthritis, Dr. Howard?

Dr. Howard: The first thing that we're all aware of is that rheumatoid arthritis has involvement of the MP's, and less often involvement of the DIP's and the PIP's. Osteoarthritis, almost in reverse of that, will have involvement of the DIP and the PIP. I find that my patients have this morning stiffness and it loosens up through the day. However when they overdo things they get pretty uncomfortable. The specific X-ray findings are joint space narrowing and osteophyte formation.

Dr. Osterman: In osteoarthritis, one may see angular deformities, particularly at the distal interphalangeal joint, of the index and long finger and, of course, there's the classic osteophyte. At the distal interphalangeal joint it's called Heberden's nodes and at the PIP's Bouchard's nodes. My patients often complain of an inability to get their rings on and off, particularly over these nodes. Sometimes they will simply have to get their rings enlarged. One of the things that can be helpful is a ring guard, which allows them to open the ring to get it over the PIP joint. Another question I frequently get from my patients is whether, when they crack their knuckles, that's going to cause osteoarthritis. Dr. Howard, what do you tell your patients?

Dr. Howard: Usually it's the parents who are suggesting that their children don't crack their knuckles and I tell them that I don't have convincing evidence one way or the other.

Dr. Osterman: What I tell my patients is that we don't know the absolute answer, but that the popping sound is created by making a

pocket as they separate the two articular surfaces and that this pulling on the ligaments will give them thicker ligaments and fatter fingers, but probably doesn't cause osteoarthritis. There have been studies which do suggest, however, that osteoarthritis follows a genetic pattern. One thing I'll ask my patients is what their grandmother's or mother's hands look like. I also remind them that the time when the osteoarthritis onsets in any particular patient is often traceable in hereditary terms. Dr. Cohen, what do you tell someone who feels that their occupation is responsible for their arthritis?

Dr. Cohen: I think you really have to analyze each case individually. There have been some reports suggesting that joint overuse may actually influence the development of osteoarthritis in the hand. I know of one study in factory workers that showed a correlation between degenerative changes and actual job activities that distributed stress to the individual interphalangeal joints. I still don't know if this is an association or an actual cause and effect. I think, however, that if you had individuals repetitively performing a certain activity, and they developed isolated interphalangeal joint disease, you could then make a case for that being associated with their work activities.

Dr. Osterman: Dr. Howard, do you have the same concept as to the relationship work may have?

Dr. Howard: I think it's important when a patient comes to see me and he wants his injury to be called a work injury, that he prove to me the mechanism of injury correlates with the physical findings and the radiographic findings. As Dr. Cohen has pointed out, I think it's important that we try to differenti-

ate these bilateral, symmetric problems that come on at the same time that the "mother's arthritic changes" have developed, from the specific injury to a specific joint that correlates with the mechanism of injury; usually it is unilateral.

Dr. Osterman: I'm in a state where as long as the activity can be felt to play a significant role, it can fall under the banner of work aggravation. I still analyze their work activities, the types of forces involved, the type of repetitiveness, as to whether the job would add further wear and tear on the joints. If there are unusual patterns and those patterns are consistent with the work activity, I would label it work related. What about the scenario of the asymptomatic joint with osteoarthritis that becomes symptomatic after an accident?

Dr. Howard: If they were asymptomatic prior to that type of injury and they become symptomatic afterwards, then I think it's related to that. However, as we've discussed, if there is some preexisting problem, then that preexisting problem must be considered.

Dr. Cohen: It seems that we are seeing more and more of these chronic problems being related to, for example, motor vehicle accidents. I have a tough time attributing symptoms from longstanding degenerative disease to a specific accident, especially without a documented injury to the particular joint in question.

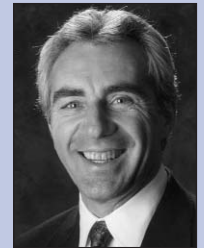
Dr. Osterman: Dr. Cohen, how do you approach the general treatment of osteoarthritis?

Dr. Cohen: I try to educate the patient by reviewing their X-rays and the natural history of the condition. Often an adjacent joint is asymptomatic but more advanced

radiographically. This helps patients understand that degeneration does not always correlate with symptoms. Aspirin or a non-steroidal anti-inflammatory agent can often be used in early or mild cases. I like the patients to see a therapist to discuss joint protection modalities. Occasionally, splints can be worn, either during sleep, during flares or for specific activities that aggravate their symptoms.

Dr. Osterman: Ms. Tull, what is your early treatment of these patients with beginning symptomatic osteoarthritis?

Ms. Tull: Conservative management helps in terms of the early treatment of symptomatic osteoarthritis. The hard part for the patient is to understand why it hurts for a while, and then when the inflammation or the pain goes away, the joint looks the same. It's a matter of educating the patient to respect the pain while still moving the joint. Exercise is part of our conservative management approach to maintain their range of motion and strength. We will teach them to use techniques that will make them feel better—supportive modalities such as heat, which most people seem to prefer. However, if they are symptomatic, an ice pack often-times provides them with better relief for a short period. When it's just achy, I think that heat seems to provide the most comfort. Paraffin



**WHAT I FIND
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LON HOWARD, MD, FAOS

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is one type of superficial heat that we'll use, which has some carry over into home use.

Dr. Osterman: How expensive are those units at home?

Ms. Tull: A ball park figure is around \$200, which can be expensive for most patients. In some cases, warm compresses can be as effective as paraffin with heat penetration of up to a centimeter of tissue. So I would recommend either type of superficial heater for home use.

Dr. Osterman: How about ionophoresis?

Ms. Tull: Ionophoresis has been shown to provide some absorption into the tissue with a low voltage direct current. I tend to use dexamethasone and lidocaine when treating the PIP joint. Most patients get better carry over of symptom relief when treating the thumb CMC joint. I'm not sure if the

delivery system is more effective, or the fact that there is differential tissue absorption.

Dr. Osterman: Dr. Cohen, what are your indications for injection in osteoarthritis?

Dr. Cohen: I don't think interphalangeal joint injections are as useful in osteoarthritis as in rheumatoid or an inflammatory arthritis. For early joint disease that is isolated to

one or two locations, I have had some success with injections, especially at the proximal interphalangeal joint level. It burns no bridges and can get individuals through a flare.

Dr. Osterman: And how do you do that injection?

Dr. Cohen: I palpate the joint dorso-laterally, and first anesthetize the skin with a 27-gauge needle. I then try to guide a 25-gauge needle with a steroid (such as Celestone) and a long acting anesthetic into the joint. I often takes several attempts to find the plane, especially in a narrowed joint.

Dr. Osterman: Dr. Howard?

Dr. Howard: I don't usually anesthetize the skin. But what I find helpful is to pull some longitudinal traction with one hand, while I'm injecting with the other hand. It seems to open up the joint.

Dr. Osterman: We have a fluoroscope unit in this office and I find it useful to help position the injection. The joints that I tend to inject most are those with erosive osteoarthritis, where the pathophysiology is that of active inflammation. I have not been particularly enamored with injecting run-of-the-mill osteoarthritis. Finally, relative to the use of splints, while I find them useful in thumb CMC osteoarthritis, I've had less luck at the interphalangeal joints. I use them mainly in erosive osteoarthritis where rest may quiet the inflammation.

Why don't we talk specifically about what medications are used? You mentioned, Dr. Cohen, that you use aspirin and a non-steroidal. Is there any particular non-steroidal that you find more effective?

Dr. Cohen: I try to have patients take Advil or Motrin. I try not to be the one prescribing long-term anti-inflammatory medication to these

patients. I would rather have their internist serve that function. I have occasionally used the newer COX-2 inhibitors, but patients can still experience gastrointestinal upset with these medications.

Dr. Osterman: Dr. Howard?

Dr. Howard: I start with aspirin, preferably an enteric coated aspirin. If they're having a problem with swelling, I will go more towards Naprosyn than Motrin since Motrin may tend to cause a little more swelling in the hands. If there is a contraindication to using these, then I'll give them a "gastric sparing smorgasbord", which is samples of Relafin, Arthrotec, Lodine, Celebrex and Vioxx. Then the one that works the best without side effects is the one I prescribe. I would prefer to have the internist or the primary care physician prescribe these.

Dr. Osterman: There are potential bleeding problems for many of the non-steroidals. I also don't think people, for osteoarthritis localized in the hand, need to be on medications day in and day out. I tell them that they should concentrate their medication usage when they're having flares. How about the use of some of the drugs which are now popularly being touted as cartilage enhancers, such as glucosamine or chondroitin sulfate?

Dr. Cohen: I have not recommended them as I have very little information on their efficacy.

Dr. Osterman: Taken as directed, three 500 mg tablets is about \$1.67 a week in my area. I've had some patients who have some anecdotal successes with them and thus, I offer it, not as something that I prescribe, but as an alternative treatment. When they ask, I say there is no data that says it's harmful or that it enhances the articular cartilage. In one Canadian study, a significant number of patients did get symptomatic relief, compared to



I DON'T THINK YOU HAVE TO... EXCISE THE ENTIRE CYST, AS LONG AS YOU DEBRIDE THE CYST ORIGIN AND THE OSTEOPHYTES.

MARK COHEN, MD

use of a placebo (59% to about 49%). Over the several year study there was no X-ray improvement.

Some patients who come in to me don't like the lumps, or they have trouble getting their rings on, etc. Have you had any experience with just doing debridement of the osteophytes?

Dr. Cohen: I have not.

Dr. Howard: I have not either.

Dr. Osterman: I have done that in selective cases, but warned the patient ahead of time that the basic pathophysiology hasn't been changed. By using a small H incision on the dorsum the surgeon can get on either side of the DIP joint osteophyte to preserve the conjoined extensor tendon. I will take a small rongeur and begin to debride the osteophytes around the collateral ligaments and on the dorsal edges. I've had some fairly gratified patients and in this anecdotal series the osteophytes did seem to stay controlled.

How do you treat the mucous cyst, Dr. Cohen?

Dr. Cohen: Many mucous cysts are asymptomatic and aside from a bump and occasionally a nail plate deformity, do not require much in the way of treatment.

Dr. Osterman: What if the patient says "Should I take a needle and pop it?"

Dr. Cohen: The cysts communicate with the joint, so popping them is probably not a good idea. The only problems I have had with mucous cysts are those treated with repetitive puncture or liquid nitrogen or dry ice by a dermatologist with actual skin loss over the cyst and the joint. These occasionally require some type of rotation flap for coverage following debridement.

Dr. Osterman: If you're going to do surgery, how do you do it? Do you always do a skin graft as has been

advocated?

Dr. Cohen: I think we now appreciate that with a thorough debridement of the osteophytes, the recurrence rate is extremely low. I have been making a transverse incision and try to debride both joint margins medial and lateral to the extensor mechanism. Often the cyst is more distal than the joint. I don't think you have to make the incision this distal or to actually dissect out and excise the entire cyst, as long as you debride the cyst origin and the osteophytes.

Dr. Osterman: I think that that is true. When I first started out in practice, I did tend to use skin grafts, but have avoided skin grafts. In recent times, I will debride the osteophytes, usually through a variation of the H incision. The major caveat is to watch out for the extensor tendon, and I will splint the DIP joint postoperatively in extension for a week or two just in case that extensor tendon has been weakened. My indications for operating on mucous cysts at the DIP joint level is low. I think that mucous cysts tend to recur in those joints that get them. Furthermore, they are a source, not only of nail bed deformities, but also of infections. Since the cyst communicates with the joint, or if a ruptured cyst is draining, the patient should be on an antibiotic. I tend to use antibiotics in the postoperative period for several days because postoperative infections, as reported by Steve Margles, are not uncommon. Dr. Howard, anything to add?

Dr. Howard: Yes. I do excise the skin when it's very thin over the most prominent portion of the cyst. I can't remember having done a skin graft, since there's always enough skin to close it primarily. I do splint them. And I watch them closely to make sure that they don't develop any postoperative infection. I don't routinely use antibiotics perioperatively.

Dr. Cohen: I think that your postoperative splinting protocol is important. If you move these patients too soon, some will develop an inflamed and swollen joint, which I do not think is infection but an inflammatory reaction.

Dr. Osterman: How about when the mucous cyst occurs at the PIP joint associated with osteoarthritis? Same treatment, Dr. Howard?

Dr. Howard: I treat them the same way, except that I'm more conservative as far as splinting. I might splint them for a total of 4 weeks.

Dr. Osterman: I believe aspiration of the cyst is useful at the PIP joint. I'll use a small 25-gauge needle to rupture the cyst and then inject the joint.

What surgical treatment is available to salvage end stage DIP joint osteoarthritis?

Dr. Cohen: Typically arthrodesis. I used to use a Herbert screw, but more often now use a 2.0 mm AO screw for arthrodesis. The Herbert screw is sometimes too large for the middle phalanx and the trailing threads can lead to nail plate problems. An important point when using 2.0 mm screws, is that you often have to order longer screws separately. In the stainless steel mini-fragment set, they only come up to a 20 mm length and only to 24 mm in the titanium mini-fragment set. Often you need a 26 or 28 mm screw to actually purchase the diaphysis of the middle phalanx.



THE MOST IMPORTANT THING, WITH TRYING TO DO RANGE OF MOTION IN THE SMALL JOINTS OF THE HAND IS TO MAKE SURE THAT YOU'RE ISOLATING PIP AND DIP MOTION. WE TEACH PATIENTS BLOCKING EXERCISES.

MARGE TULL, PT, CHT

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Dr. Howard: I agree with Dr. Cohen and I try to make sure that I countersink at the distal end of the distal phalanx so that I don't have a palpable prominent screw head.

Dr. Osterman: And what type of incision do you use?

Dr. Howard: I will use a longitudinal incision, on the side with the most deformity and then transverse. Occasionally I have to extend it to a full H, but am frequently able to do it with a T shape incision.

Dr. Osterman: Do you split the extensor? Do you detach it via insertional DIP joint, the conjoint tendon?

Dr. Howard: I leave it attached, and I try to go radial and ulnar to that so that I haven't disrupted the extensor mechanism.

Dr. Osterman: I find it difficult to expose the joint, debride it to cancellous surfaces, and level an angular deformity if I don't at least mobilize the extensor tendon. I tend to split it longitudinally and mobilize it as a composite flap with the joint capsules going radially and then ulnarly so that I've taken it out of the dorsal portion of the collateral ligaments. This exposure allows me to flex the joint down and prepare the surfaces. If it is detached, it should be reattached as you can get a swan neck deformity secondary to leaving it unattached.

Dr. Cohen: I cut it transversely and repair it.

Dr. Osterman: That's equally good, even though you're doing a fusion at that joint. It gives you soft tissue support if your fusion doesn't completely take, as well as preventing a

secondary swan neck deformity. For fusion, I most commonly use a Herbert screw, though I think you can have problems with the thumb because of its larger interphalangeal joint, and there I'll use an accessory pin, or one of the larger screws, even using an Acutrak or a Herbert Whipple to help control rotation.

What's your post operative regimen, Dr. Cohen, after you've done a DIP fusion?

Dr. Cohen: Postoperatively, I immobilize for 7-10 days and, depending on the patient, he or she can either begin more normal activities avoiding directly applied pressure to the fingertip or, in the more active patient you're concerned about, protect the fusion with a small gutter or mallet-type splint.

Dr. Osterman: Ms. Tull, how do you manage postoperatively DIP joint fusions?

Ms. Tull: If the physician prefers to splint, we might make a little cap splint for protection. If they have had pain and swelling prior to the procedure, the digit oftentimes is very stiff because the patient has been guarding it. So we will direct treatment to regain range of motion at the PIP and MP joints. The idea is to protect the fusion and regain mobility and function. Their pinch and grip may be altered which may require modifications for gripping handles, tools or sporting apparatus.

Dr. Osterman: Do you prefer a cap splint that's dorsal or volar? Do you think it makes a difference?

Ms. Tull: I think it depends on the type of arthritic finger you're looking at. If the dorsal surface is thin skinned and bumpy, then I would prefer a volar splint. But sometimes I will use both the volar and the dorsal just to get a good fit as long as there is no skin abrasion. Most patients appreciate the added protection.

Dr. Osterman: That is important. Later, if I still want some protection for the fusion we will switch to a smaller figure 8 DIP splint that leaves the pulp surface free for use.

Dr. Howard, do you use bone graft when you do DIP fusions?

Dr. Howard: I don't. I feel that if I can get a good bone on bone apposition, a good 10-20 degrees of flexion, and good fixation on the diaphyses of the middle phalanx, then I don't use bone graft.

Dr. Osterman: I will use bone graft if I have erosive osteoarthritis. Where do you get your bone graft if you need it?

Dr. Howard: I would take it from any excised osteophytes if they were adequate. If not, I would take it from the distal radius through the third compartment.

Dr. Cohen: When needed I use the distal radius and enter just proximal to Lister's tubercle. Often you see the third compartment but I don't like to violate this.

Dr. Osterman: I usually take it from the second compartment. I use a Craig needle biopsy needle which provides a little bit of core of bone that is easy to harvest and all you have to do is be careful not to violate the radial articular surface. Is there any indication ever, Dr. Cohen, for joint arthroplasty at the DIP joint?

Dr. Cohen: I'm sure there may be some individual with a specific need for distal interphalangeal joint motion, but probably the majority should be treated with a fusion.

Dr. Osterman: Fusion is the gold standard, but there is the occasional case where you may want to preserve DIP joint motion. For example, someone who had a stiff non-salvageable PIP joint or a particular need for DIP joint motion. A classic

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Neural Nets

Since the beginning of computer technology, "artificial intelligence" has been conceptualized. Interestingly and appropriately, the roots of artificial intelligence are based squarely upon research of the biological brain. Despite an incomplete understanding of the complex organic structure, basic neural physiology has been the platform for computer programs that can "think and learn."

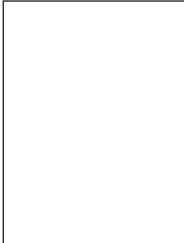
In the 1940's, the thesis of the formal neuron was proposed. In this mathematical model of the biological component, function was delineated as a weighted summation of inflow. Action in the form of transmission occurred only if a threshold of inflow was met. Training was explained on the basis of strengthening or weakening of synaptic efficiencies that would, in turn, control outflow transmission.

Computerized neural networks, conceptualized in the 1960's, became reality in the 1980's. Multiple layers of electronic "neurons" with complex feedback loops began to achieve validation and justification. Actual numeric data passing through subsequent layers of the neural networks generates data thresholds called "weights." Once the model has been trained, applying the weights to new data can make predictions. And of course, faster and faster computers can accommodate huge numbers of nodes in and layers adding power to the neural net application.


Currently, neural net applications are used every day in the finance industry as well as in many industrial processes where numeric data are reviewed. Descriptive medical information is not acceptable for current neural net engines; however, non-linear neural net analysis can be performed on medical data where standard numeric measurements are made. The predictive capabilities are impressive!

As with standard multi-variant analysis, large data volumes stabilize results, and predicted parameters from insufficient data are unreliable. The advantages of the neural net over more traditional methods are as follows:

1. The ability to interchange and optimize both input and output parameters rapidly without limitations on the number of variables,
2. The capability to configure optimization of variables (examples: inclining desirability for range of motion or strength; declining desirability for post-operative treatment days), and
3. Avoidance of normal distribution curve assumptions (examples: smoking or age).



J. DANIEL LABS, MD

Look for an increasing role of neural nets in medicine as we computerize in the next millennium! 

Announcing the 4th Annual Day at the Links

being held in conjunction with the AAHS
and ASRM Annual Meetings

Saturday, January 8, 2000
1:00 pm Shotgun Start, Presidential Golf Course

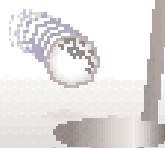
Cost: \$150.00

Registration Deadline:
5:00 pm, January 7, 2000

Cost includes: Greens fees, cart rental,
transportation, box lunch and 2 drink tickets

Prizes: Cash prizes will be awarded for
lowest gross score for a team, as well
as for the longest drive, longest
putt and closest to the pin

For more information, call
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4th Annual Day at the Links Registration Form

NAME _____

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PHONE _____ FAX _____

HANDICAP (If HC is not known, please indicate scores from the last three rounds of golf played)

Payment Method VISA MASTERCARD CHECK

CARD NUMBER _____ EXP. DATE _____

SIGNATURE _____

Please fax this back to the AAHS/ASRM Central Offices at 312-782-0553 or mail to,
AAHS/ASRM, Golf Registration, 20 N. Michigan Avenue, Suite 700, Chicago, IL 60602.

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example is a violinist who needed both interphalangeal joint flexion as well as extension. The prosthesis at the DIP joints come in sizes 0 and 00. I try to use the larger size. I prefer the lateral approach because it doesn't violate the extensor and flexor mechanisms. How do you treat the patient who has a osteoarthritis of the distal interphalangeal joint, Dr. Cohen, and who then develops a degenerative mallet finger?

Dr. Cohen: I would treat it conservatively in a mallet splint and see how they did, especially if they were asymptomatic before.

Dr. Osterman: Dr. Howard, any difference?

Dr. Howard: Yes. I repair them surgically and remove the osteophyte and any mucous cysts.

Dr. Osterman: I tend to follow Dr. Cohen's lead, in that I think most of these occur when they rupture the tendon over that osteophyte, but they do heal fairly much like the standard mallet and in fact, even a little bit better than that because of the osteoarthritis stiffness. I'll splint them for about 4-6 weeks max, not the 8-10 that I do for a standard tendinous mallet. What are your indications, Dr. Cohen, for arthroplasty at the PIP joints?

Dr. Cohen: I think the ulnar digits, the ring and small and probably the middle, are most appropriate for arthroplasty in the older, lower demand individual. In a young active patient or someone with bone loss or a gross angular deformity or instability, I think an

arthroplasty is probably not the best option. However, PIP fusion of the ring or the small finger in an otherwise normal hand can functionally be quite disabling.

Dr. Osterman: What kind of range of motion would be an indication? In other words, someone comes in and says "I only have 25 degrees of motion, it's painless, but I have trouble gripping things." Would that be an indication for arthroplasty?

Dr. Cohen: Unless they had more than approximately 30 degrees of motion preoperatively, I think an arthrodesis is probably indicated when an operation is needed. I'm not sure I would do an arthroplasty in somebody with 20 degrees of motion at the PIP joint preoperatively.

Dr. Howard: I think if I had a patient with 25 degrees range of motion

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without significant pain, I'd send that patient to my therapist.

Dr. Osterman: Ms. Tull?

Ms. Tull: The most important thing, I find, with trying to do range of motion in the small joints of the hand is to make sure that you're isolating PIP and DIP motion. We teach patients blocking exercises, holding the MP in extension so as to direct the forces to the PIP joint. Sometimes patients are amazed how their range of motion improves. Prior to therapy, heating of the tissue helps for better tissue extensibility. In some cases, splinting may be indicated.

Dr. Osterman: My indications for PIP joint replacement are pain at the proximal interphalangeal joint, significant angular deformity, particularly in the ulnar three digits, or a limited non-functional range of motion. If they have stiff DIP joints from osteoarthritis and now have stiff PIP joints, the patient ends up with only large object grasp with their MP joint flexion. PIP joint replacement can restore small object grasp. Because of the lateral pinch forces involved, I do fuse the index PIP joint. Relative to PIP joint replacements, Dr. Cohen, what exposure do you use and what prosthesis?

Dr. Cohen: I use a dorsal exposure, through the central tendon, taking care not to violate the central slip insertion. I think that you can remove the head of the proximal phalanx and get an awl into the base of the middle phalanx without violating the integrity of the central slip. I have used the Sutter prosthesis.

Dr. Osterman: OK, Dr. Howard?

Dr. Howard: I use the same approach that Dr. Cohen does. I try to be prepared to repair the central slip if I'm not able to preserve it. I use the Swanson prosthesis.

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CODING CORNER

ICD-9-CM Coding for Osteoarthritis Requires Specificity

Osteoarthritis and allied disorders begin with 715 under the ICD-9-CM coding system. This category includes arthritis or polyarthritis—both degenerative and hypertrophic, degenerative joint disease, and **osteoarthritis**. A fourth digit is then used to designate the distribution of the disease. This may be “generalized” or “localized” to specific anatomic areas. See Table 1. When coding it is therefore necessary to first determine whether the disease is generalized or localized. If “generalized” start with 715.0. If “localized” select 715.1 for “localized, primary”, 715.2 for “localized, secondary”, 715.3 for localized but “not specified

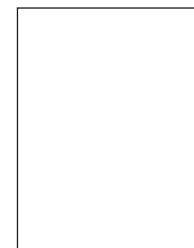
whether primary or secondary”. A frequently employed ICD-9 code for osteoarthritis hand surgery is 715.8 which designates **more than one site**, as in multiple digit involvement, but not where the disease is **not generalized**. If it is not known whether the disease is generalized or localized, then use 715.9.

In addition, a fifth digit is required with all osteoarthritis codes to further identify the exact location of the disease. In the upper extremity these digits run 1 through 4. See Table 2. Note that fifth digits 8 - “other specified sites” and 9 - “multiple sites” are “nonspecific” codes and should be avoided if a more exact designation of site can be coded.

Coding Example

Arthroplasties are performed for osteoarthritis of multiple digits. The disease is localized to the hands. **ICD - 9 - CM code: 715.84.** i.e. more than one site, not generalized, involving the hand.

Good luck and good coding! **H**



STILES T. JEWETT, JR., MD, FACS

TABLE 1

TABLE 1	
715.0	Osteoarthritis, generalized Degenerative joint disease, involving multiple joints Primary generalized hypertrophic osteoarthritis
715.1	Osteoarthritis, localized, primary Localized osteoarthropathy, idiopathic
715.2	Osteoarthritis, localized, secondary
715.8	Osteoarthritis involving, or with mention of more than one site, but not specified as generalized
715.9	Osteoarthritis, unspecified whether generalized or localized

TABLE 2

TABLE 2	
Fifth digit subclassifications for use with category 715.	
0	Site Unspecified
1	Shoulder Region Acromioclavicular joint(s) Clavicle Glenohumeral joint(s) Scapula Sternoclavicular joint(s)
2	Upper Arm Elbow joint Humerus
3	Forearm Radius Wrist joint Ulna
4	Hand Carpus Phalanges Metacarpus

Hand Surgery Quarterly

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Dr. Osterman: I'm the odd man out here. For osteoarthritis I almost never use a dorsal approach. I use either a lateral approach or a volar approach. In my practice the extensor mechanism is much harder to re-balance. Given the relative mechanical weakness of the extensor compared to the flexors, rehabilitation is also easier. I, therefore, approach the joint much like in a volar plate arthroplasty. I use a Bruner approach over the PIP joint, open the A-3 pulley, reflect the flexor tendons, and then release the volar plate and the volar portions of the collateral ligaments. I open the joint like a shot gun, prepare both surfaces and the canals with an awl or burr, and then use a Swanson prosthesis sized 2 or 3. Closure involves a repair of the volar plate. I check the passive range of motion in the OR so that's normal, zero to 115-120.

What kind of postoperative things do you do for patients who've had a PIP arthroplasty, Ms. Tull?

Ms. Tull: Well, that depends on the surgical approach that's taken. I see mainly volar approaches. We begin therapy on day 2-3 after the surgery for active range of motion. They are in a digital extension splint between exercise periods. We progress flexion as tolerated. I might initially make them a volar template to control the progression of flexion. If there has been other than a volar approach, a dorsal approach, I'll specifically be more careful to monitor for extension lag. If you do a dorsal approach and need to do a central slip repair, do you ever then consider dynamic extension?

Dr. Howard: I splint them for at least three, if not four weeks. If I've been unsuccessful in preserving the central slip, then I might splint them for an extra two weeks.

Dr. Cohen: I like a dynamic extension splint if they are having problems with an extensor lag or if I think the central slip needs protection in the early postoperative period similar to the MP arthroplasty.

Ms. Tull: We do just use the extension splint for the digit and may sometimes buddy it with the adjacent digit. Extension splinting will continue for a total of 6 weeks. Then the patient performs active exercises for the first three weeks. Afterwards, we begin some passive exercise if there is stiffness. If they're not responding to therapy by the fourth to sixth week, we might try some dynamic splinting. We occasionally use flexion bands or straps, but caution must be used for the DIP joint. We will begin some strengthening, usually at the sixth week, followed by reinforcement of joint conservation and protection. In some cases, modification of their activities is necessary.

Dr. Osterman: Do you find Coban

helpful for swelling in the early postoperative period?

Ms. Tull: Yes, it has a marked effect on the reduction of edema. In some cases, we'll incorporate it as part of the home program.

Dr. Osterman: How about blocking splints?

Ms. Tull: I will use blocking splints at the MP to direct the motion to the PIP. Other times, with a PIP arthroplasty, we'll even use a little cap splint over the DIP to isolate the motion to the PIP joint.

Dr. Osterman: I would agree with you. We would start such blocking at about three weeks if the joint motion was not improving. I like the motion at three weeks to be approaching 80 degrees. What's your average postoperative motion in the PIP joint arthroplasties, Dr. Cohen?

Dr. Cohen: If we achieve 70 or 80

degrees of flexion, I'm pretty happy. While function seems to be preserved, these patients seem to lose some degree of motion over time.

Dr. Osterman: Dr. Howard?

Dr. Howard: I tell my patients that my target motion is for full extension and 90 degrees of flexion. I tell him that we can't get there, and if we can have them attain a range of motion from 10 degrees to 75 degrees then I'm pretty happy with that.

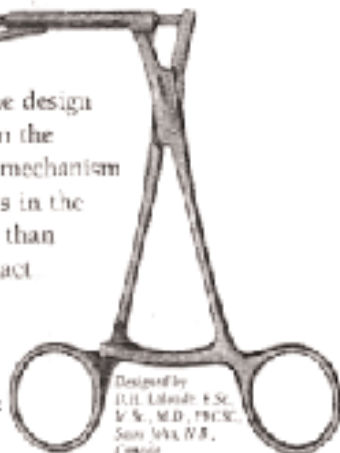
Dr. Osterman: I think that's a very reasonable result. I try to aim for about a 70-80 degree arc of motion, with extension of 10 to 15 degrees. And I do find that there is some late fall off at the five year follow up where I see about a 10 degree change. But such deterioration depends on whether their DIP's have gotten stiff. If their DIP's

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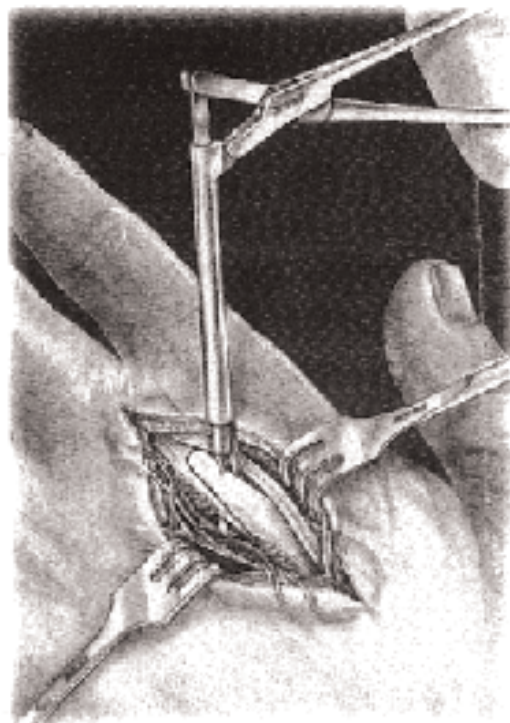
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AROUND THE TABLE

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remain mobile they tend to emphasize PIP joint flexion less in ADL and lose some of the early motion that was initially obtained. Some of my best results of PIP replacement have been in patients who have DIP fusions. Both of you agreed with me that fusion of the PIP joint of the index finger was standard. How do you do that fusion, Dr. Cohen?

Dr. Cohen: I typically use a small tension band wire technique for the PIP joint using 0.35 mm Kirschner wires and a 26-gauge monofilament wire. The textbooks seem to recommend slightly more flexion than we use. For the index, I think approximately 20 degrees works

well, and ulnarly we try not to go more than 40-45 degrees. Slightly greater flexion may be helpful for some activities, but with more flexion patients seem to have trouble getting their hand into their pockets or their gloves. They seem to prefer a slightly straighter position than that often recommended for both function and cosmesis.

Dr. Osterman: Dr. Howard?

Dr. Howard: I use a little more flexion than Dr. Cohen does. I try to shoot for 35 degrees of flexion at the PIP joint of the index finger. I use a lag screw, countersinking at the distal metaphysis of the proximal phalanx, and trying to get good diaphyseal purchase in the middle phalanx.

Dr. Osterman: How do you shape the bone?

Dr. Howard: I use a saw, because I feel like I can get a smooth surface on both sides.

Dr. Osterman: I use a tiny microsagittal saw to cut the desired angle and agree with Dr. Cohen's angles of fusion: about 15-20 at the PIP joint of the index. Since it is used as a pointer, if you fuse more than 20 degrees, everybody starts looking at the floor when they're pointing at the wall. When I do fuse the ulnarly PIP joints, as I said, more often than not in osteoarthritis I'll replace them. I tend to use less flexion than classically described: 30 degrees or so in the long finger, 35 and 40 respectively in the ring and small. I use a tension band technique. Do you find you have to remove those wires when you use a tension band, Dr. Cohen?

2001 Application for Research Grants

The AAHS Research Grant Awards were established to further the purpose of the Association as stated in its Bylaws and to foster creativity and innovation in basic and/or clinical research in all areas pertinent to hand surgery.

Awards and Eligibility

Grants will be made for a one year period to up to three investigators. Grants are available to all AAHS members. One of the investigators must be an **active** or **affiliate** member of the association.

Grant Application

Applications may be obtained from:
American Association for Hand Surgery
20 N. Michigan Avenue, Suite 700
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Applications (**an original plus seven copies**) must be received by the committee chair no later than **Friday, December 1, 2000**, in order for the judging to be completed in time and the recipients to be announced at the Annual Meeting.

The AAHS and the Research Committee are required by the IRS to document disbursement of grant funds. Award recipients will be required to sign a letter of acceptance and submit a progress report once each year. The AAHS must be acknowledged as the source of funding in any presentation or publication. A final report must be submitted at the completion of the study. It is expected that the results of the funded research be submitted for presentation at an Annual Meeting within two years of the receipt of the award.

Funds must be returned to the AAHS if the study is not undertaken within twelve months of the receipt of the award.

Failure to follow these guidelines will disqualify the recipient from any further grant opportunities and from presenting any papers at the AAHS Annual Meeting for a period of three years following such default.

Mail Grant Proposals to

William Lineaweaver, MD
812 Arlington Street
Jackson, MS 39202



Dr. Cohen: Typically not. If the Kirschner wires are bent along the bone, this seems to be a very low profile technique. When the wires back out and they become prominent, often a bigger problem exists, mainly a non-union.

Dr. Osterman: What do you do with your lag screw, Dr. Howard?

Dr. Howard: I leave the screw in. I haven't found a problem with that. As I said, if you're able to counter-sink it, it's not going to disrupt the extensor tendon.

Dr. Osterman: And do you have problems getting rotational control with the single screw?

Dr. Howard: I've been lucky so far. Again, I think with the compression you put with the screw, if you have smooth cuts with the sagittal saw then that does give you the rotational stability that you need.

Dr. Osterman: What if you have a failure of a previous fusion?

Dr. Howard: I would use the plate and screws in a non-union of a previous fusion. And when I do use a plate and screws, I've taken them out after I have a solid arthrodesis.

Dr. Osterman: With my routine tension band fusion, I find that I take out about 20% of those pins once the fusion is solid. Some of the tricks which have kept the fixators asymptomatic is to bury the tension band wire end into the bone through a separate hole in the proximal phalanx. Another trick is before finally setting the two 0.35 k-wires, I'll pull them slightly back but still in the shaft. I'll then bend them, and then curve them back in so that they now are totally flush to the bone and not across the DIP joint. I use a plate when there is severe erosive osteoarthritis, since the tension band is an unstable construct in those patients. I use bone graft to add stability to the

construct. One thing that we should all point out is that, whether you do an arthroplasty or a fusion, it is important to warn your patient that the finger will be somewhat shorter. For fusion I use a dorsal approach to the PIP joint.

Are there any other questions or things that we should add?

Dr. Howard: Since I am from New Hampshire, I suggest patients use mittens rather than gloves because they will frequently have some cold intolerance.

Dr. Osterman: What do you think about the future developments in the treatment of osteoarthritis of the interphalangeal joints?

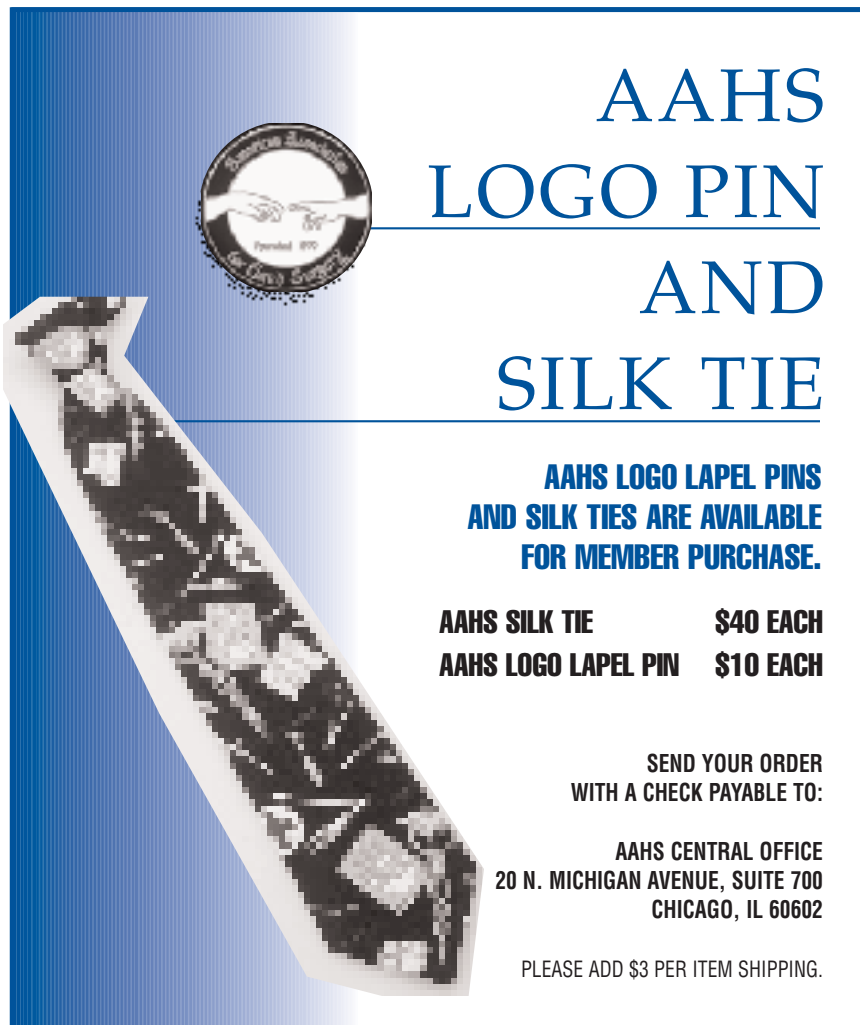
Dr. Howard: I think that we're learning more every day. In the future

will be something similar to sinvisc to help small condyle defects and synovitis. Now sinvisc is basically when you have an active synovitis.

Dr. Osterman: How about cartilage replacement therapies that are used in large joints?

Dr. Cohen: I'm not sure, but I think the interphalangeal joints are different from the hip and knee by virtue of their size and loading. We've pretty much been doing the same things for arthritic fingers for the past 20-30 years and I'm not sure changes will be as rapid as we might otherwise think. We may, however, have more options for prevention of disease.

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The advertisement features a blue background with a white diagonal banner on the left side. At the top left is the AAHS logo, a circular seal with the text "American Association of Hand Surgeons" and "Founded 1970". Below the logo is a large, detailed image of a black silk tie with a white geometric pattern. To the right of the tie, the text "AAHS LOGO PIN AND SILK TIE" is written in large, bold, blue letters. Below this, in smaller blue text, it says "AAHS LOGO LAPEL PINS AND SILK TIES ARE AVAILABLE FOR MEMBER PURCHASE." A table lists the items and prices: "AAHS SILK TIE \$40 EACH" and "AAHS LOGO LAPEL PIN \$10 EACH". Below the table, it says "SEND YOUR ORDER WITH A CHECK PAYABLE TO:" followed by the address "AAHS CENTRAL OFFICE 20 N. MICHIGAN AVENUE, SUITE 700 CHICAGO, IL 60602". At the bottom, it says "PLEASE ADD \$3 PER ITEM SHIPPING."

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Dr. Osterman: Ms. Tull, how about therapy?

Ms. Tull: Joint protection has not changed either. Any references that I reviewed from the last 20 to 30 years were basically the same. The surgical approaches are changing and the way to rehab needs to change. In terms of conservation methods, they're still pretty much the same as they were. I think in the future, as a large segment of the population approaches age 50, there will be more and more people who will need early intervention and preventative treatment.

Dr. Osterman: As I see the future, I think there will be an increasing emphasis on, "What can I do prophylactically to halt the osteoarthritic process or modify it?" I think you will see discussions about what exercises are best. There may be some role early on for medications which are bone inhibiting so that we may be able to block the osteoblastic response. Cartilage replacement may play a role, particularly in the PIP joint. We're all aware of some of the work that's now being done in traumatic joints where you can replace part of the cartilage surface with autograft cartilage from another surface. There may be some different fusion techniques which allow actually percutaneous fusion based on an infusible substance. One of the last things I would add is that there are already several prototypes for resurfacing a PIP joint arthroplasty that are already on trial in several clinics with mixed results.

I thank you all very much for your participation in this discussion. **H**

HAND THERAPY PROFILE

David Bierwagen PT, CHT



DAVID BIERWAGEN, PT, CHT

Personal: Home is in Jamesville, NY, a suburb of Syracuse, with my wife Lori and two daughters, Ashley and Taylor. Enjoying athletics and the outdoors, our leisure time is spent with softball, biking, boating, and water and snow skiing, to name a few.

Education: Following graduation from St. Lawrence University with a bachelor's degree in Biology, I returned to Ithaca College to receive a degree in Physical Therapy.

Employer: I am presently self-employed as owner of Orthopedic Rehabilitation Services, PT, PC, having two offices in the Syracuse area.

Best Parts of the Job: The best part of the job is that in the 20+ years of my career I have looked forward to going to work everyday with each day being a different day. The enjoyment comes from the people I have been privileged to work with, both as patients and professional associates.

Major Accomplishments: The most gratifying professional accomplishment has been to earn the respect of physicians, in the Syracuse area, for our profession. Also enjoying being around young people and students; I have been able to influence and positively effect a good number of them and their efforts to further their education in Physical Therapy.

Clinical Specialties: Clinical specialties include all facets of upper extremity rehabilitation as well as general orthopedic and sports medicine.

Greatest Challenges: Aside from the present intrusions on private practice, there has always been the challenge of remaining knowledgeable and current and consequently clinically effective.

AAHS Involvement: I have been an affiliate member of AAHS for approximately 15 years. I was encouraged to join by the Hand Surgeons which I, at the time, was affiliated with. My reason for joining was to have another resource for information which has proven to be the case.

Three words that describe me: Keep the Faith. **H**

Resources for the Hand Therapist on Osteoarthritis

By S. Michlovitz, PT, PhD

For those interested in reading about osteoarthritis (in addition to this issue's Around the Hand Table), there are an abundance of contemporary resources. Traditional texts, journals and the Internet have information that will assist in enhancing patient care. I included a few new ones below.

Some Recommended Books:

Bennett, K. Therapeutic exercise for arthritis. In Hall, CM, Thein-Brody, eds. *Therapeutic Exercise: Moving Toward Function*, Philadelphia: Lippincott Williams & Wilkins, 1999; pp. 185-199.

Melvin J, Jensen G, eds. Rheumatologic Rehabilitation Series: Assessment and Management, (Vol 1) Bethesda, Md: the American Occupational Therapy Association, Inc., 1998. (The first book in a 3-part series, check <http://www.aota.org> for future volumes.)

Some Journal Resources:

Brandt KD, ed. Osteoarthritis, Rheum Dis Clin North Am May, 1999; 25(2). Three articles would be of special interest to the therapist:

1. Hurley MV, The role of muscle weakness in the pathogenesis of osteoarthritis. pp. 283-298.
2. Sharma L. Proprioceptive impairment in knee osteoarthritis. pp. 299-314. (Discussion on importance of proprioception in maintenance of joint stability-granted its not the hand, but principles can be learned work done in other regions).
3. Minor MA. Exercise in the treatment of osteoarthritis. pp. 397-416.

Kozin SH. Arthroplasty of the hand and wrist: Surgeon's perspective. *J Hand Ther.* 1999;12(2):123-132.

Michlovitz SL, Kozin SH, eds. Special Issue: Osteoarthritis and Traumatic Arthritis of the Upper Quadrant. *J Hand Ther* (in preparation for April/June 2000)

AAHS Hand Therapy Sponsored Pre-Conference Seminar

January 5, 2000

Loew's Miami Beach Hotel

South Beach, Florida

Fracture Management: Evidence Based-Surgical and Therapy Practice

7:30-8:00 am	Registration and continental breakfast
8:00-8:10 am	Introduction: Framework for evidence-based practice. <i>Susan Michlovitz, PT, PhD</i>
8:10-8:50 am	Assessing fractures: implications for diagnosis and management (including imaging studies). <i>Scott Kozin, MD</i>
8:55-9:35 am	Advances in fracture management-internal fixation and bone graft substitutes. <i>Mark Cohen, MD</i>
9:40-10:15 am	Optimizing functional outcome: choosing in-clinic supervised therapy or a home program. <i>Colette Jewell, OTR/L, CHT</i>
10:15-10:30 am	Break
10:30-11:00 am	Complications after fractures: recognition and management.
11:00-11:25 am	Managing concomitant nerve injuries. <i>Christine Novak, PT, MS</i>
11:30-11:50 am	Managing soft tissue loss after complex fractures. <i>William Swartz, MD</i>
11:50 am-12:15 pm	Vargas Trip: Surgery and Therapy in Egypt. <i>Katherine Scofield, OTR/L, CHT and Nash Naam, MD</i>
12:15-1:15 pm	Boxed lunch
1:15 pm	Case study: Phalangeal Fracture. <i>Alan Freeland, MD and Maureen Hardy, PT, MS, CHT</i>
1:45 pm	Case Study: Metacarpal Fracture. <i>Alan Freeland, MD and Maureen Hardy, PT, MS, CHT</i>
2:15 pm	Case Study: Distal Radius Fracture. <i>Susan DeStefano, OTR/L, CHT and Paul Zidel, MD</i>
2:45 pm	Case Study: Wrist Fracture. <i>Scott Kozin, MD and Susan Michlovitz, PT, PhD</i>
3:15-3:30 pm	Break
3:30 pm	Case Study: "Both bone" forearm fracture. <i>Paul Brach, PT, MS, CHT and Dean Sotereanos, MD</i>
4:00 pm	Case Study: Elbow fracture. <i>Paul Brach, PT, MS, CHT and Mark Cohen, MD</i>
4:30 pm	Panel Discussion Why do fingers get stiff after wrist fracture? Early predictors for RSD? Therapy is capitated.... And more...

HAND THERAPY

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Some Internet Resources

<http://www.arthritis.org> (site for the Arthritis Foundation)

<http://www.orthopedics.medscape.com> (home page for orthopedics specialty—has links to other sites, including Medline)

<http://www.e-hand.com> (from Charles Eaton, MD, AAHS member)

<http://www.nlm.nih.gov> (Medline)

<http://www.secrest.com> (linked to Medical Multimedia Group, a Montana based company that produces interactive CD-ROM for patient education). 

American Association for Hand Surgery Calendar

2001

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

2002

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

2003

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

For information contact:

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2000

January 5, 2000
Board of Directors Meeting
Miami, Florida

January 5-8, 2000
30th Annual Meeting
Loews Miami Beach Hotel
South Miami Beach, Florida

January 7, 2000
Board of Directors Meeting
Miami, Florida

July, 2000
Mid-Year Board of Directors Meeting
Chicago, Illinois

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