A Publication of the
American Association for Hand Surgery

HAND SURGERY QUARTERLY

Winter 2009

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444 E. Algonquin Road
Arlington Heights, Illinois
60004

Report for AAHS Hand Surgery Endowment Volunteer Outreach Program

Dates: Sept. 30–Oct. 2, 2008

Locations:

- **Crownpoint Healthcare Facility, Crownpoint, NM serving the Eastern most part of the Navaho Reservation. The service unit covers 4,200 square miles and serves a population of about 27,000 tribal members. This facility offers outpatient care and inpatient obstetrical care.**
- **Acoma-Canoncito-Laguna Hospital, San Fidel, NM, serving these three tribes with about 14,000 tribal members. This hospital offers outpatient and dental care and several specialty clinics. Currently under construction is a dialysis center. They also have some on-site housing for staff.**

The ACL Hospital in San Fidel, New Mexico

ACL Hospital staff (PT) with HSE representatives George Irons, MD (far left) and Juli Howell, PT, CHT (far right).

This program required a lot of planning. To name a few of those who I was directly involved with and to thank them for their assistance: Alice Romano from the HSE office who did the initial "casting ofthe net" for volunteers, Sue Michlovitz and Aviva Wolff, HSE Board Members, who participated in the selection of a volunteer hand surgeon and a volunteer certified hand therapist. On the local level Andra Battocchio, Director of Rehabilitation Services at the Chinle Comprehensive Health Care Facility, Chinle, AZ coordinated the selected hand surgeon, myself and hand therapist, Juli Howell, with the PT directors, Lori Lee at Crownpoint and Scott Mitchell at ACL. This was truly a team effort by many.

We communicated with the PI Directors at both sites over a period of about three weeks to determine how we could best serve their needs and the time frame that would work best for the health care staff of their facilities. They took a poll of the entire medical staff for suggestions and received a lot of input which was forwarded to us. This formed the basis for our program. We then worked together to formulate a program that included: evaluation, diagnosis, conservative treatment, surgery and hand therapy, each of us addressing

continued

REPORT FROM HSE

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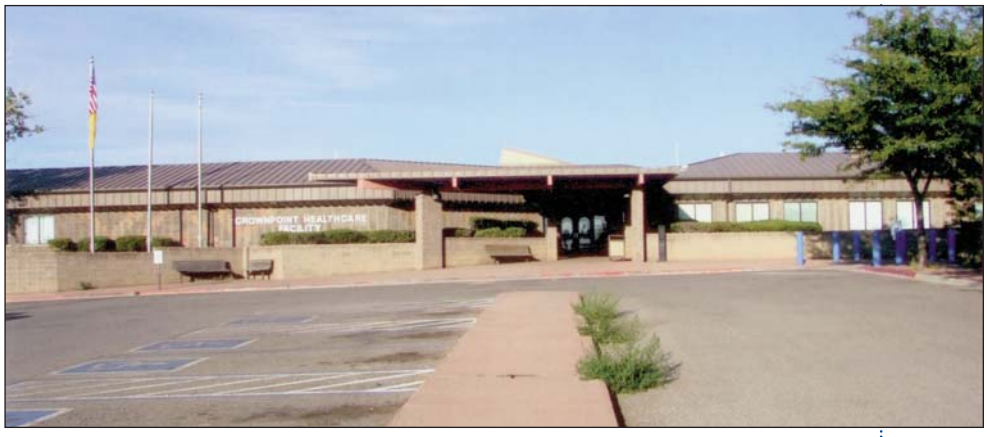
our areas of expertise and complimenting each other. Juli spent a lot of time working with the PT's on splinting techniques. Our overall goal was to add to the knowledge base of the medical staff in hopes that in tum it would translate to better care for the patients they served.

We had a couple of focuses for our presentations and discussions:

1. The Importance of Balance in the Hand – As an example: Using span grasp to hold a hot cup of coffee and keep from crushing the cup or dropping it requires a delicate balance between the long flexors, long extensors and the intrinsic muscles as well as sensory feedback and motor control by the median and ulnar nerves.
   What provides balance? This necessitated a review of the anatomy particularly of the intrinsic muscles. We used a lot of medical illustrations. What disturbs balance? Fractures, muscle and tendon injuries and disease and nerve deficits were discussed. What can we do about it? We discussed prevention, conservative and surgical treatment.
2. Some Common Conditions That Effect the Hand, most of which had been mentioned in the staff poll: Carpal Tunnel Syndrome, Trigger Finger, deQuervain's Tenosynovitis, Dupuytren's Contracture and hand trauma as well as other things that they had questions about. Several physicians were interested in techniques for injections in the hand.

We both took some supplies which we donated to the PT Departments: hand grip meters, electric fry pan for heating water to make splints, splint material, wrist splints and books.



Crownpoint Health Care Facility

Crownpoint

Crownpoint PT staff with HSE representatives George Irons, MD, and Juli Howell, PT, CHT

The facilities and local support were very good. The attendance more than met our expectations. They seemed appreciative of our efforts. We put considerable time and effort into this adventure but both feel that it was worthwhile and a satisfying experience. We appreciate the Hand Surgery Endowment giving us the opportunity to be of service to the Native Peoples.

George Irons, MD

Hand Surgery in the Third World

The theme of this issue is "hand surgery in the third world". This is a topic of longstanding interest to AAHS, dating back to the early 1990's, when AAHS initiated the Vargas award, the first program that I am aware of that specifically sponsored hand therapists to visit underprivileged areas, not just to treat, but to teach. One of the first Vargas programs, to Guatemala, spun off the Guatemala Healing Hands Foundation, which now sponsors annual trips to that country. Over the years AAHS members, therapist and surgeons alike, have traveled to South and Central America, Eastern Europe, Asia and Africa. This issues "Around the Hand Table" explores some of the lessons learned from those trips.

Although the term 'third world' was originally coined to describe countries that were not aligned with either the western (first) or eastern/communist (second) "worlds", the term has always also implied poverty and a risk, if not the presence, of abuse and exploitation at the hands of the first two worlds. Indeed (Wikipedia is SO helpful!) the term was coined by a French social scientist, Alfred Sauvy, writing in the left wing French magazine "L'Observateur, in 1952. Sauvy described these countries, mostly colonies or former colonies of 'first world' nations, as being similar to the French third estate (tiers-état, the bourgeoisie of pre-Revolutionary France that were so abused by the nobles (first estate) and clergy (second estate). Sauvy wrote: "car enfin, ce Tiers Monde ignoré, exploité, méprisé comme le Tiers Etat, veut lui aussi, être quelque chose" ("...because at the end this ignored, exploited, scorned Third World like the Third Estate, wants to become something too").

In contrast the terms first and second world never caught on; most writers, including Sauvy, preferred the terms West and East to describe these two other worlds, which shared a common interest in exploiting the third one. The nations Sauvy identified then, mostly in South and Central America, South Asia and Africa, remain today among the poorest lands on the planet, excepting only a few small states such as Singapore, and to some extent India, which contains within its vast subcontinent a middle class the size of Europe's, while at the same time containing population of profoundly poor people larger than that found in Africa. One can even argue, with cause, that many of these lands remain ignored, exploited and scorned. The tragic death of a single child in America traumatizes us so much that we know these children by name, as if they were members of our own families- Amber has an alert named after her, Megan a law, and Caley, Jacob, and Adam, to name just a few, are so well known that many will know their stories simply by the mention of their first names. In contrast, millions of third world children die regularly of preventable disease, war, famine, or abuse, in countries most Americans would be hard pressed to locate, let alone wonder about.

PETER C. AMADIO MD

Yet it is too easy to fall into the trap of either blaming these countries for their own misfortune, or blaming the more developed world for it, as if the third world had, like a small infant, no control over itself or its destiny. Jared Diamond famously blamed it all on "Guns, Germs and Steel", the hypothesis that climate and natural resources explained the fates of societies. But that is clearly not so. Governments, and the actions of a people in a society, often play a decisive role. Free societies, with the rule of law and clearly defined and protected property rights, are far more likely to succeed than autocratic ones. Which is why the fates of Europe and China diverged in the 16th century (and now, with a more open society in China, are converging again). Third world countries can "become something too" by changing their form of government, and many have. We can help, by providing examples and assistance, but ultimately the third world will either rise and stand on its own feet, or choose to remain lying down, more as a result of decisions made there, than of decisions made here. Thankfully, more and more countries are standing up, becoming something good for their citizens, and for the world.

It is in to such rising countries that our intrepid volunteers have

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HAND SURGERY QUARTERLY

President
Scott H. Kozin, MD

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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.

EDITOR'S DESK

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journeyed, to speed the rate of progress in hand care in other lands, and to provide care where it otherwise might not exist. Yet let there be no mistaking: this is a two way exchange. Those who need to make do with less are often more innovative, and certainly more economical- lessons we can benefit from as we attempt to slow the runaway growth of health care expenses in the West.

We owe our volunteers much thanks for what they do. Of course, one need not look to third worlds for challenges; we have them near enough, in our own inner cities and in many rural areas. Do what you can to help. It won't ever be enough, but it will make a difference. H

MESSAGE FROM THE PRESIDENT

An Overview of What's Coming Up

ANNUAL MEETING – Maui, Hawaii:

The Annual Meeting in Maui, Hawaii has had a tremendous attendance response. The room block is over 100% filled, sponsorships are up, and exhibitor support is high. Hopefully you have made your hotel reservations: the hotel has provided additional rooms as needed. The final program has been mailed, replete with education, camaraderie, and social events.

The guest speaker is Daniel Gottlieb, PhD a psychologist and family therapist. Dr. Gottlieb hosts an award-winning health calling NPR show. Dr. Gottlieb was also in a near fatal automobile accident that left him quadriplegic. Dr. Gottlieb is an accomplished author and his lectures are moving and introspective. Dr. Gottlieb will be available for a book signing following his keynote speaker presentation.

Lewis Carter, MD, an AAHS member who spends the majority of time in Africa, will be the Danyo Lecturer. Dr. Carter is diligently preparing his lecture, which will focus on volunteerism and his commitment to developing/emerging countries.

SCOTT H. KOZIN, MD

AMA:

At the annual meeting, Andrew W. Gurman, MD who is Vice Speaker of AMA House of Delegates will provide information critical to the practicing physician. Recently, the AMA has changed its criteria for an organization to maintain its seat in the house. This change has benefited the American Association for Hand Surgery and we now fulfill this criteria.

2008 ORTHOPAEDIC UNITY SUMMIT:

The American Academy of Orthopaedic Surgery held an Orthopaedic Unity Summit in October. This was the second Orthopaedic Unity Summit and included leaders from 26 orthopaedic specialty societies. From the American Association for Hand Surgery, Drs. Kozin, Rekant, Hughes and Bindra attended. The meeting was very informative. Breakout sessions discussed communication, healthcare policy, research, and education. In the future, the AAHS is dedicated to

continued

American Association for Hand Surgery 2009 Slate of Officers

President	**Nicholas Vedder, MD** (automatic)
President Elect	**A. Lee Osterman, MD, FACS** (automatic)
Vice President	**Steven McCabe, MD**
Treasurer-Elect	**Michael Neumeister, MD**
Historian	**Randipsingh Bindra, MD, FACS**
Senior Director-at-Large	**Miguel Pirela-Cruz, MD**
Junior Director-at-Large	**Donald Lalonde, MD**
Junior Affiliate Director	**Susan Michlovitz, PT, PhD, CHT**
Nominating Committee	**Elvin Zook, MD** **Richard Berger, MD, PhD**

FROM THE PRESIDENT

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combining efforts with the American Society for Surgery of the Hand to strengthen the role of hand surgery in the orthopaedic community. Many initiatives came from the meeting that will be continued throughout this year and for years to come.

OVERSEAS EDUCATION:

Nash Naam, MD has organized the second international meeting in the Mideast. The meeting will take place in January shortly after our annual meeting. AAHS faculty members include Drs. Kozin, Baratz, Berger, Naam, Adams and Russell. The AAHS is devoted to sharing knowledge with developing/emerging hand societies. This effort fosters our goal as an international educator. Dr. Naam has worked hard to organize and finalize the program. He deserves immense credit.

MANAGEMENT:

The AAHS Board is changing management services. We appreciate the many years of service from ISMS and have begun the transition to Specially Associate Management Services "SAMS". We have hired a new Executive Director, Emily Freeman, who will be attending the annual meeting. She has wonderful personal and professional attributes and I encourage you to introduce yourself to her.

I am so excited about the annual meeting in Hawaii and hope to see you there. I guarantee your time will be full of education with ample time for fun. If you have any questions about the meeting, please visit the website www.handsurgery.org or feel free to contact me anytime skozin@shrinenet.org. H

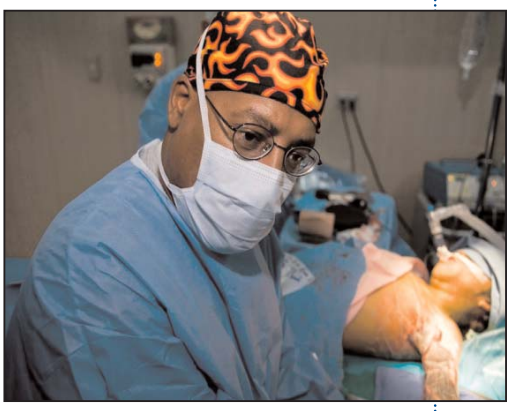
ASSOCIATION NEWS

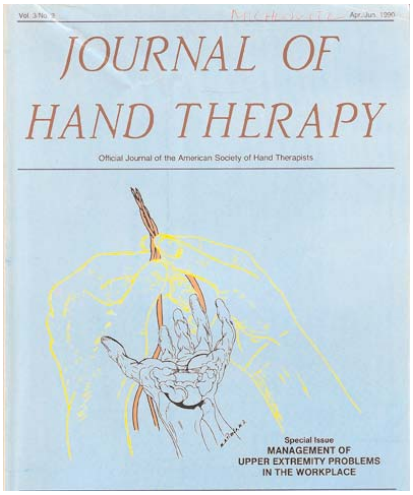
ASHT 2008 Honorary Member Award

Miguel Pirela-Cruz, MD has been named ASHT 2008 Honorary Member for contributions to hand care and hand therapy.

Dr. Pirela-Cruz is an accomplished medical illustrator. In his spare time he is active in many organizations: the American Association for Hand Surgery, attending all hand therapy specialty days; the American Society for Surgery of the Hand; and the Guatemala Healing Hands Foundation, teaching therapists. Dr. Pirela-Cruz has served as an examiner for the American Board of Orthopaedic Surgery, author in *Journal of Hand Therapy,* the U.S. Public Health Service, and Lt. Colonel Flight Surgeon in the U.S. Air Force Reserve.

His paid work is as Professor and Regional Chair, Department of Orthopaedic Surgery, Texas Tech University Health Sciences, El Paso, Texas, as a hand surgeon and trauma surgeon. Dr. Pirela-Cruz is well known for donating his time, expertise and creativity. H





Vascular Disorders of the Hand/Reimplantation
William C. Pederson, MD

Compressive Neuropathies & CRPS
Daniel Nagle, MD

Thumb Basal Joint Arthritis and Wrist Arthritis
Alejandro Badia, MD

Inflammatory Arthritis of the Hand and Wrist
Matt Tomaino, MD

Distal Radius Fractures
Peter J. L. Jebson, MD

Distal Radioulnar Joint
Brian Adams, MD

Scaphoid Fractures and Non-Unions
Mike Hayton, FRCS

Brachial Plexus Injuries
Randy Bindra, MD

Carpal Instability
Peter Amadio, MD

Fractures of the Metacarpals and Phalanges
Marco Rizzo, MD

Flexor & Extensor Tendon Injuries
Kevin J. Renfree, MD

Infections of the Hand
Kevin D. Plancher, MD, MS, FACS, FAAOS

Congenital Hand Diffferences
Scott H. Kozin, MD

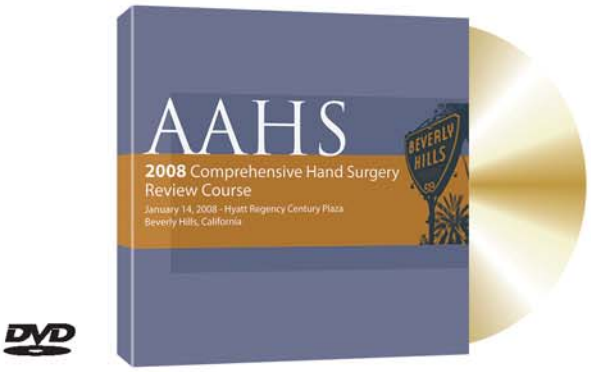
Tumors of the Hand and Wrist
Michael Bednar, MD

Soft Tissue Coverage in the Hands
Loree Kallianen, MD

Tendon Transfers for the Hand
Randy Bindra, MD

Tendon Transfers for the Hand
Peter M. Murray

Tendonopathies and Dupuytren's Contracture
Peter M. Murray, MD



A must-have resource.

Purchase this special limited edition DVD and put the entire 2008 Comprehensive Hand Surgery Review Course at your fingertips. This invaluable resource includes faculty presentations of 18 topics covered on board examinations, the hand surgery certification examination and resident in-training examinations. Recorded during the AAHS 2008 Annual Meeting, it's a resource you'll turn to over and over again.

To place an order, complete the form below and send it via fax or mail. Phone orders will also be accepted. Quantities are limited. ***$175 per copy, includes shipping.***

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President-Elect Nicholas Vedder, MD

Nicholas Vedder, MD is Professor of Surgery and Orthopaedics, Vice Chair of the Department of Surgery, and Chief of the Division of Plastic Surgery at the University of Washington in Seattle, where he has been a member of the full-time faculty since 1990. He is a past Chair of the Plastic Surgery Research Council and is currently Vice Chair of the American Board of Plastic Surgery, where he served on the Hand Advisory Council as the AAHS representative from 2000-2004 and currently serves on the Tripartite (ABOS/ABPS/ABS) Joint Committee for Surgery of the Hand. He is also a Director of the American Board of Surgery and a member of the Plastic Surgery RRC.

Dr. Vedder has been a member of the AAHS since 1995 and served as a Junior Director at Large from 1996-1998, Parliamentarian from 1999-2000, and Senior Director at Large 2005-2007. He is also the AAHS Alternate Deligate to the AMA. He has participated in, organized, and moderated a number of educational panels and symposia of the association and has served on the program committee. He has also held officer positions in numerous other, regional and national organizations, and is the Hand Section Editor of the journal, Plastic & Reconstructive Surgery. In addition to He holds active certification in Surgery, and Plastic Surgery, he holds active certification inand Surgery of the Hand.

Nick is a native of Chicago, but after meeting his future wife at Stanford as an undergraduate, he has been a committed "west-coaster" ever since and has lived in the Seattle area for 26 of the last 28 years. He graduated AOA from Case Western Reserve University, and then completed a full residency in Surgery at the University of Washington, followed by a two-year NIH research fellowship, then Plastic Surgery Residency under former AAHS President Jim May at the Massachusetts General Hospital, where he fell in love with hand surgery. He was the first hand surgery fellow at the University of Washington in 1990 under current ASSH Vice President, Tom Trumble. Since then, he has collaborated with Tom and his orthopedic and plastic surgery hand colleagues at the University of Washington to help build a model, truly combined orthopedic-plastic surgery hand service that centers around one of the top hand surgery training programs nationwide.

Nick has always been attracted to the AAHS because of its open, inclusive, and interdisciplinary nature, highlighting the best and brightest contributions to the science and education of hand surgery from surgeons and therapists from all backgrounds and disciplines, enjoying the benefits of collaboration, friendship, and mutual respect. He has always been completely committed to hand surgery and his current academic practice at the University of Washington continues to focus almost exclusively on hand and extremity reconstruction. As Chief of one of the most highly sought after plastic surgery residencies, he takes great joy in enlightening residents in plastic surgery, surgery, and orthopedics to the joys and intrinsic rewards of hand surgery.

Nick is also a very active member of the ASSH and has served on a number of ASSH committees; including the program committee on several occasions and Chair of the highly successful ASSH Annual Comprehensive Review Course. He strongly believes that the AAHS plays a unique and critical role in promoting the science and education of hand surgery and that close cooperation and collaboration between the two major hand societies is extremely important to the future of the specialty.

Nick has two children, Katie, 21, and Nick, 2019, both in college. His wife, Susan Heckbert, MD is a Professor of Epidemiology at the University of Washington and a world-renowned cardiovascular epidemiologist. He and his wife live on Mercer Island and their favorite pastime is sailing on Puget Sound, which they enjoy year-round. For many years they have enjoyed the annual AAHS meeting as a family event and plan to continue to do so in the future.

As AAHS President, he looks forward to promoting unity within the field of hand surgery, involving hand surgeons from all backgrounds, as well as hand therapists, from the AAHS and all hand-related organizations to capitalize on our individual strengths and shared commitments to work together for the future of hand surgery. H

Amanda Higgins, OT

Personal: I was born and raised in Quispamsis, New Brunswick Canada. This is a town on the outskirts of Saint John, the largest city in the Province of New Brunswick. New Brunswick is part of the Atlantic Provinces on the east coast of Canada. I am active in the Saint John Theatre Company and recently performed in the musical Chicago. I also enjoy yoga, adult ballet and modern dance classes. Shayne Graham, my partner of 5 years, and I live in a brand new house we just had built in Rothesay, NB.

Education: After high school, I left Quispamsis and attended Mount Allison University in Sackville, New Brunswick. I loved Mt. Allison and earned a Bachelor of Science Degree in Chemistry. During my third year of the program; I was not sure what I wanted to do for a career. After talking with a friend of my mother who is a community occupational therapist and loves her profession; I decided to apply to Occupational Therapy programs. I graduated from Dalhousie University in Halifax, Nova Scotia with a Bachelor of Science in Occupational Therapy in 2002.

Employer: I decided to come home for one year and work at the Saint John Regional Hospital and pay off some of my student loan. I held an occupational therapy position in a general family medicine practice area. I was not crazy about my job. One of my practicum while I was in OT school was in the area of plastic surgery, specifically upper extremity disorders, traumas or diseases. I knew this was the service area I wanted to work in. At the end of my first year at the Saint John Regional Hospital a maternity leave position in the plastic surgery service area became available. I applied and was hired temporarily. I loved what I was doing. I was very lucky that the person I filled in for decided not to come back to work. I have been working with the plastic surgery department at the Saint John Regional Hospital as part of the upper extremity therapy program for 6 years now.

AAHS Involvement: I work with Dr. Donald Lalonde who has been a member of AAHS for several years. Dr. Lalonde told me about AAHS and encouraged me to attend the AAHS meeting in January 2008 in Beverly Hills. I enjoyed the conference, especially the specialty day. I made a lot of connections with brilliant hand therapists during the splinting workshop at the end of the day. Chris Novak was kind enough to write a letter on my behalf to apply to become an affiliate member and I was accepted. This is my first year as a member of AAHS. I hope to see many of you at the 2009 conference in Maui!!

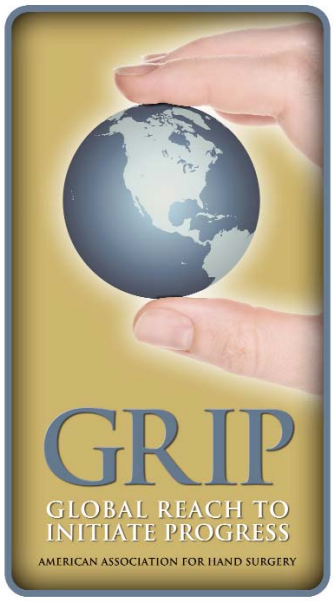
Best Part of My Job: I work with a fantastic team! The therapy team is comprised of me, Carolyn Smith (OT) and Susan Kean (PT, CHT). We work terrifically with Dr. Don Lalonde, Dr. James O'Brien, Dr. Geoff Cook, Dr. Joan Sauvageau and Dr. Gerry Sparkes. Not a day goes by that the surgical team does not recognize the efforts and triumphant of their therapists. We have been invited to work in the plastic surgery clinics with the surgeons allowing us to have weekly contact with each of them to discuss patient progress, or to meet patients for the first time together and discuss treatment options, or to observe live anatomy during wide awake hand procedures. I love coming to work everyday because I feel appreciated and I am treated with professional respect.

Major Accomplishments: I presented at the International Federation of Societies for Hand Therapists (IFSHT) in March 2007 in Sydney, Australia; The Treatment Process for Flexor Tendon Repair/Reconstruction Begins during Surgery. I climbed the Sydney Harbour Bridge!! I am presenting during the Flexor Tendon Program at the AAHS meeting in Maui. I have contributed on a couple publications with the plastic surgery residents I work with.

Clinical Specialties: I love working with thermoplastics, neoprene and other materials to create splints. I especially enjoy working with people who have had tendon injuries.

Greatest Professional Challenge: I have learned to be flexible with "protocols". I do not fit the patient to a protocol, I let the patient and the situation of the patient help me to understand how to treat their issue and determine what therapeutic recommendations I can give to them. I am looking for an online Masters Degree in Hand Therapy program that does not require the participant to have CHT designation.

Three Words That Describe Me: Patient, positive, enthusiastic. H



AAHS 39th Annual Meeting

January 7–10, 2009
Grand Wailea Resort
Wailea, Maui, HI

Wednesday, January 7, 2009

6:00–7:00am Continental Breakfast

7:00–3:00pm Specialty Day Program: Complex Trauma: Management and Rehabilitation

7:00–7:15am Welcome
Scott Kozin, MD, President
Miguel Pirela-Cruz, MD, Program Chair
Rebecca Von Der Heyde, MS, OTR/L, CHT, Specialty Day Chair

7:15–8:15am Traumatic Amputations

7:15–7:35am Putting It Back Together Again: Surgical Replantation
William Dzwierzynski, MD

7:35–7:55am Finding the Happy Medium: Splinting and Motion Following Replantation
Gretchen Kaiser Bodell, OTD, OTR/L, MBA, CHT

7:55–8:15am To Salvage or Not to Salvage? Case Presentations
Nicholas Vedder, MD

8:15–8:35am Restoration of Power: Nerve Grafting and Transfers
Susan Mackinnon, MD

8:35–8:55am Power Surge: Rehabilitation Following Nerve Grafting and Transfers
Christine Novak, MS, PT

8:55–9:15am Role Reversal: Nuts and Bolts of Tendon Transfers
Scott Kozin, MD

9:15–9:35am Finding a New Path: Neuromuscular Re-Education
Aviva Wolff, OTR/L, CHT

9:35–9:55am Coffee

9:55–11:00am Panel: Hands Around the World: Complex Cases from Medical Missions
Lynn Bassini, MA, OTR, CHT
Sharon Dest, PT, CHT
Sue Michlovitz, PT, PhD, CHT

11:00–12:00pm Panel: Multi-Trauma Case Presentations
Miguel Pirela-Cruz, MD, Moderator
Paul Brach, PT, CHT
James Chang, MD
A. Lee Osterman, MD, FACS
Rebecca Von Der Heyde, MS, OTR/L, CHT

12:00–1:00pm Specialty Day Lunch

1:00–2:00pm Case Studies: What I Learn When Things Go Awry: Modified Methods for Maximal Outcomes
Aviva Wolff, OTR/L, CHT, Moderator
Mary Nordlie, MS, OTR/L. CHT
Ann Lund, OTR/L, CHT
Cia Passig, OTR/L, CHT

2:00–3:00pm Your Statistician's Diagnosis: How to Tell When You Need a Second Opinion on Your Research Project
Sue Michlovitz, PT, PhD, CHT
Paul Velleman, PhD

1:00–6:00pm Trauma Pre-Course: Standard of Care or Stretching the Indications
William C. Pederson, MD, Moderator
Randy Bindra, MD, Moderator

Additional CME 4.75 Credits. $100 additional registration required.

1:00–1:20pm Plating is the Optimal Treatment for Displaced Clavicle Fractures
William Geissler, MD

1:20–1:40pm Nerve Transfers Provide a More Predictable Outcome Than Proximal Nerve Repairs
Thomas Tung, MD

1:40–2:00pm Should We Always Reconstruct the Ulnar Artery in Hypothenar Hammer Syndrome?
Craig Johnson, MD

2:00–2:20pm Is Replantation of Single Finger Distal to the FDS Insertion Still a Valid Indication?
Minoru Shibata, MD

2:20–2:40pm Q & A

2:40–3:10pm Debate: All Minimally Displaced Distal Radius Fractures Should Be Managed Surgically
Brian Adams, MD
David Nelson, MD

3:10–3:30pm Break

3:30–3:50pm Should All Scaphoid Nonunions Have a Vascularized Bone Graft?
Alexander Shin, MD

3:50–4:10pm The Role of Bone-Ligament-Bone Repair for Acute Scapholunate Dissociations
Richard Berger, MD

4:10–4:30pm The Hamatometacarpal Joint: Is It Just for Spare Parts for the PIP?
Greg Sommerkamp, MD

4:30–4:50pm Usefulness of 2-Stage Reconstruction in Neglected Profundus Tendon Ruptures
John Taras, MD

4:50–5:10pm The Role of Ulnar Head Replacement in Distal Ulna Fracture Reconstruction
Sanjay Desai, MD

5:10–5:30pm Q&A

5:30–6:00pm Debate: All Non-Displaced Scaphoid Fractures Should Be Fixed With a Screw
Joe Dias, MD
Joseph Slade, MD

5:00–6:00pm Hand Therapist Reception

6:00–8:00pm AAHS Welcome Reception

continued

Thursday, January 8, 2009

6:00–7:30am Coffee

6:30–7:30am Instructional Courses

101 **CMC Arthritis: Arthroscopy, Anchovy, & Implants**
Alejandro Badia, MD, Moderator
Robert Beckenbaugh, MD
John Lubahn, MD

102 **Flexor Tendon Repair – Are We Any Better?**
Eduardo Gonzalez-Hernandez, MD, Moderator
Donald Lalonde, MD
Michael Neumeister, MD
Amanda Higgins, OT

103 **Scapholunate Ligament: An Update on Repair**
Richard Berger, MD, Moderator
William Geissler, MD

104 **Success in Private Practice (Surgical Centers, Therapy, Passive Income, Reimbursement)**
Kyle Bickel, MD, Moderator
Allen Berkowitz, MD
Ross Nathan, MD

105 **Total Wrist Arthroplasty: Indications, Surgery and Rehabilitation**
Brian Adams, MD

106 **Treatment of Complications after Wrist Fracture – Malunion, Nonunion, Infection**
Phil Heyman, MD
Rob Medoff, MD
Jorge Orbay, MD
Tom Wright, MD

7:45–8:00am **Welcome**

Presidential Welcome
Scott Kozin, MD

Program Chair Welcome
Miguel Pirela-Cruz, MD

Vargas Award Recipient

ASSH President
L. Andrew Koman, MD

8:00–9:00am **Panel: Minimally Invasive Fracture Fixation - How I Do It!**
Jesse Jupiter, MD, Moderator
A. Lee Osterman, MD, FACS
Alexander Shin, MD

9:00–9:30am **Breakfast**

9:30–10:30am **Hand Editorial Board Meeting**

9:30–11:00am **Concurrent Scientific Paper Session A-1**

9:30–11:00am **Concurrent Scientific Paper Session A-2**

11:15–12:00pm **Presidential Address**
Scott H. Kozin, MD
"The Power of Pinch"

12:00–1:15pm **Keynote Speaker and Book Signing**
Daniel Gottlieb, PhD
"The Art of Caring"

1:15–1:30pm **AMA House of Delegates**
Andrew W. Gurman, MD, Vice Speaker

1:30–2:30pm **Instructional Courses**

107 **Elbow Trauma and Coverage**
Milan Stevanovich, MD, Moderator
Stephen Trigg, MD

108 **Intercarpal Fusions: What Works and What Does Not Work!**
David Bozentka, MD
Steven Moran, MD
Michael Sauerbier, MD

109 **Nerve Compression and Repair**
John Taras, MD, Moderator
Jeff Yao, MD
Robert Spinner, MD

110 **Pediatric Brachial Plexus Injury**
Allen T. Bishop, MD, Moderator
Howard Clarke, MD
Scott Kozin, MD

111 **Scaphoid Fractures and Nonunions: Arthroscopic, Percutaneous, Re-vascularization**
T. Greg Sommerkamp, MD, Moderator
Alexander Shin, MD
Joseph Slade, MD

112 **Tendonitis, Tendonopathy, Tendon Rupture About the Elbow**
Peter Evans, MD, PhD
Jeff Greenberg, MD
Scott Steinman, MD

3:00–5:00pm **Bioskills Courses**

BC-1 **Endoscopic Cubital Tunnel Release**
Tyson Cobb, MD

BC-2 **Avoiding Problems with Distal Radius Fixation**
Miguel Pirela-Cruz, MD
A. Lee Osterman, MD
Mark Rekant, MD
Rob Medoff, MD

BC-3 **Surgical Tips in Treating Distal Radius Fractures**
Jaiyoung Ryu, MD

3:30–4:30pm **Instructional Courses**

113 **Nerve Transfers for the Upper Extremity—What Works**
Susan MacKinnon, MD
Christine Novak, MS PT
Justin Brown, MD

114 **Burn Management**
Roger Simpson, MD

115 **Financial Course – Life Financial Goals for Physicians**
Patrick R. Donnelly, CIMA - Smith Barney Consulting Group
Jeffrey M. Palmer - Smith Barney Consulting Group

Friday, January 9, 2009

6:00–7:45am Coffee

6:30–7:30am Instructional Courses

116 **Humanitarian Care in a Combat Arena**
Eric Hofmeister, MD, Moderator
Brian Fitzgerald, MD
Gregory Hill, MD
Michael Thompson, MD

117 **Peripheral Nerve Repair and Reconstruction—Glue, Tubes, etc.**
Susan MacKinnon, MD, Moderator
John Taras, MD
Allen Van Beek, MD

118 **PIP Joint – Update on Replacement & Condylar Replacement Techniques**
T. Greg Sommerkamp, MD, Moderator
Peter Murray, MD
Kevin Chung, MD

119 **Radial Head Repair vs. Replacement—Why, When & How!**
Mark Baratz, MD, Moderator

120 **Ulnar Sided Wrist Update – Sauve, Darrach, U-Head**
Kevin Renfree, MD
Luis Scheker, MD
Joseph Slade, MD

121 **Wound Coverage: Kids to Adults**
Nicholas Vedder, MD, Moderator
Benjamin Chang, MD

continued

Anthony Smith, MD

7:45–9:15am **Concurrent Scientific Paper Session B-1**

7:45–9:15am **Concurrent Scientific Paper Session B-2**

9:15–9:45am **Breakfast with Exhibitors**

9:45–10:45am **Panel: How to Maximize Reimbursement in Practice**
Kyle Bickel, MD, Moderator
Steve Leibovic, MD
Daniel Nagle, MD

10:45–11:15am **Joseph Danyo Invited Speaker**
Louis L. Carter, Jr. MD, FACS
"Caring for the Disabled and Deformed in the Emerging World—What a Privilege!"

11:15am–12:00pm **Panel: Update on Nerve Reconstruction – Grafts, Transfers, Glue, Transfers**
Susan Mackinnon, MD, Moderator
Christine Novak, PT, MS, PhD(c)
Alexander Shin, MD
Thomas Trumble, MD

12:00–12:30pm **Annual Business Meeting (AAHS Members only)**

12:45–2:45pm **Board of Directors Luncheon**

12:30–5:45pm **Comprehensive Hand Surgery Review Course**
Additional CME 5.0 Credits
Steven L. Moran, MD, Chairman
$100. Additional Registration Required. Box lunch will be served.

12:30–12:50pm **Tendonopathies and Dupuytrens Contracture**
Jennifer M. Wolf, MD

12:50–1:10 pm **Compressive Neuropathies & CRPS**
Robert Spinner, MD

1:10–1:30pm **Thumb Basal Joint Arthritis and Inflammatory Arthritis**
Marco Rizzo, MD

1:30–1:50pm **Distal Radius Fractures**
David Dennison, MD

1:50–2:10pm **Distal Radioulnar Joint**
Brian Adams, MD

2:10–2:30pm **Scaphoid Fractures and Non-Unions, Kienbocks Disease**
Alexander Y. Shin, MD

2:30–2:50pm **Carpal Instability, Wrist Arthritis**
Steven L. Moran, MD

2:50–3:10pm **Fractures of the Metacarpals and Phalanges**
Brian Carlsen, MD

3:10–3:30pm **Break with Exhibitors**

3:30–3:50pm **Flexor & Extensor Tendon Injuries**
Jeffery Friedrich, MD

3:50–4:05pm **Infections of the Hand**
Kevin D. Plancher, MD, MS, FACS, FAAOS

4:05–4:25pm **Congenital Hand Differences**
Steven L. Moran, MD

4:25–4:45pm **Tumors of the Hand and Wrist**
Carol Morris, MD

4:45–5:00pm **Soft Tissue Coverage in the Hands**
William C. Pederson, MD

5:00–5:20pm **Tendon Transfers for the Hand**
Doug Sammer, MD

5:20–5:40pm **Vascular Disorders of the Hand/ Reimplantation**
Peter M. Murray, MD

7:00–10:00pm **AAHS Awards Dinner/Dance**
Jimmy Mac and the Kool Kats

AAHS-ASPN-ASRM
Saturday, January 10, 2009

6:45–8:15am **Coffee**

7:00–8:00am **AAHS/ASPN/ASRM Instructional Courses**

201 **Pedicled and Free Flap Reconstructionfor Trauma and Tumors of the Upper Extremity**
Amit Gupta, MD
Joseph Upton, MD

202 **Current State-of-the-Art Toe Transfers for Thumb and Finger Reconstruction**
Gregory Buncke, MD
Neil F. Jones, MD
Fu Chan Wei, MD

203 **Introduction to Acupuncture: Principles and Applications**
Lawrence J. Rossi Jr. MD, FAAP, DABMA

204 **Multiple Nerve Transfers for Control of Upper Extremity Myoelectric Prostheses (Targeted Reinnervation)**
Greg Dumanian, MD

205 **Bridging the Nerve Gap**
James Chang, MD
Susan MacKinnon, MD
Allen Van Beek, MD

206 **Brachial Plexus Surgery–What Works and What Does Not Work**
Allen Bishop, MD
Howard M. Clarke, MD, PhD
Robert Spinner, MD

8:15–8:30am **AAHS/ASPN/ASRM President's Welcome**
Scott H. Kozin, MD, AAHS President
Robert C. Russell, MD, ASPN President
Neil F. Jones, MD, ASRM President

8:30–9:30am **AAHS/ASPN/ASRM PANEL: Crisis In Hand Trauma Coverage**
L. Scott Levin, MD, FACS, Moderator
Neil F. Jones, MD
E. Anne Ouellette, MD
William C. Pederson, MD
Luis Scheker, MD
Milan Stevanovic, MD

9:30–10:00am **Breakfast with Exhibitors**

10:00–11:00am **AAHS/ASPN/ASRM PANEL: Medical Diplomacy–Volunteering, Training, and the Military**
Miguel Pirela-Cruz, MD, Co-Moderator
Eric Hofmeister, MD, Co-Moderator
Lynn Bassini, OTR, CHT
Nash Naam, MD
Eric Thompson, MD

11:00–12:00pm **AAHS/ASPN/ASRM Presidents Invited Lecturer**
Graham Gumley, MD
"Helping Our Hands Restore Their Own Feeling"

12:00pm **AAHS/ASRM Golf Tournament Wailea Country Club: Gold Course**

12:00–5:00pm **ASRM Master Series**

1:00–3:00pm **ASPN Programming**

6:00–8:00pm **ASPN/ASRM Welcome Reception** H

Hand Surgery in the Third World

The moderator for this edition of Around the Hand Table is ***Allen Van Beek, MD,*** *Clinical Professor of Plastic Surgery, University Minnesota, Edina, MN. Joining him are well-travelled experts* ***Miguel Pirela-Cruz, MD,*** *Associate Professor of Orthopaedic Surgery, Texas Tech University, El Paso, TX;* ***Warren Schubert, MD,*** *Professor, University of Minnesota, Chair, Dept of Plastic & Hand Surgery, Regions Hospital, St. Paul, MN; and* ***Lynn Bassini, OTR, CHT,*** *Brooklyn, NY.*

Dr. Van Beek: I would like to discuss these key points: What is the experience that you've had on your mission trips with hands; compare the safety of hand surgery versus some of the other things we do on trips; what do you have to take along on a trip if you're going to do hands; how do you fund trips; and, what do you do about follow-up?

Lynn, you've been organizing mission trips to Guatemala. What do you think is important from the standpoint of planning the trip? When do you start planning it, how do you go about planning a trip that's going to involve hand surgery?

Ms. Bassini: Well the more you go, the better it is. The hardest trip to plan is probably the 1st one, and then you hope to learn from your mistakes and you learn from experience—it is a work in progress. I've learned not to assume, and not to leave too much to the others to do for you. I do believe we have to work with our host country. We want to get them involved, to organize a conference or organize screening, get appropriate professionals, get support etc. We must work closely and have common goals. Because of culture or language differences, things may not be clear and problems will happen.

Dr. Van Beek: Warren, you go to some more remote mission sites, what do you think are the important steps in planning a trip that would involve hand surgery to remote sites?

Dr. Schubert: I think the most important thing is to make sure you've had some responsible people make a pilot trip to wherever you're going to gain a better idea of the institution that they're going to be working in. Really knowing what the logistics are, whether there's a water supply, whether there's electricity, how many hours is electricity is available, whether there's really a way to house and feed the team, whether there are anesthesia machines, are they calibrated, are they safe, do you have access to resupply gas and oxygen for the machines. Are you going to use your own anesthesiologist, can you trust their anesthesiologist, do they have an autoclave. If they have an autoclave, does it really work, and if it works does it really work in the volume of turnover that you're going to need it if you have a team doing possibly 20 times more cases a day than they're used to. Do they have instruments, or do you need to bring them. What do you really know about your host? Is your host really going to support you, do they truly want you there? Is there a priest or doctor or politician that has begged that you come, only to find that the institution where you're going to may not really be that enthusiastic about your being there. Are they really going to find patients for you? Are you going to have the volume of patients and the right patients, and is anybody going to look after them afterwards.

Dr. Van Beek: Miguel, when you go on trips, how much in advance do you think there should be an exploration of cases that should be done, or even a site visit? What are your thoughts about that—doing a site visit and the timing of a site visit before you take a team there?

Dr. Pirela-Cruz: Well absolutely, we probably need to do several site visits just to really get a handle and get a feel for the environment and know exactly what the deficiencies are that you have to provide for. The more familiar you are with the environment, knowing what kind of support you're going to have, what kind of reception, the more it really helps in terms of the planning. A lot of local doctors truly want to be involved, but they just don't have the infrastructure and the means to be able to do a lot. When you get them to buy into what you're trying to accomplish, it becomes very helpful. And certainly that's what we try to do with our mission.

IT'S VERY INTERESTING, BECAUSE THERE'S 3 SURGEONS HERE, AND ALL 3 OF US HAVE HAD EXPERIENCES WITH MALIGNANT HYPOTHERMIA ON OUR TRIPS.

ALLEN VAN BEEK, MD

Dr. Van Beek: How much in advance do you begin the planning? Lynn, how much in advance do you have to do the planning for a trip from the standpoint of therapy?

Ms. Bassini: As soon as we're done with one mission, we start working on the next. Or even during the existing mission we're working on the NEXT, because the crucial com-

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ponents of our missions are really education and follow up. It never stops.

Dr. Van Beek: It's a little bit different for surgeons, Warren, because of everything from equipment and so forth. And it's a little bit different when you go to a different site each time. What do you think the risks are if you go to the same place versus if you're going to a different place where a team hasn't been? What are the risk factors that the team needs to be aware of if they're not going back to the same site over and over? Because I think most of you are going to the same site repeatedly, what about teams that don't?

Dr. Schubert: If you're going to a new site the risks are tenfold, and your only prayer is to really have done a lot of groundwork as far as the site visit ideally with multiple people. Members of the site visit should include a surgeon, an anesthesiologist, and a nurse who can really sniff things out and get a feel for what each of the different health care work teams are going to need. Another important aspect is to determine is whether you think you can depend on the ancillary support people that are there, or whether you're going to have to bring mainly your own people.

Dr. Van Beek: One of the things you mentioned, Lynn, is the educational piece. There seem to be two types of education: the process where we educate them, and the process of them teaching us. How should we handle the language barriers, and what have you done, for instance, in therapy, where often essential.

Ms. Bassini: Yes, I agree totally, education goes both ways. They teach us as much as we teach them. During our mission groups we try to have translators, and many of our volunteers speak Spanish. We also use local people to translate. We try to have a translator for every three non-Spanish speaking volunteers. Guatemala Healing Hands gives an annual scholarship to a Guatemalan hand therapist to travel to the United States. This requires that the therapist learn sufficient English and then return to Guatemala to share what he/she has learned. We are trying to improve on our communication skills, both in English and Spanish. There is potential for grave problems if post surgical orders are not clear, or problems when a parent accepts a surgery that they did not really understand, or understand what the results or follow-up would be.

Dr. Schubert: Allen, one point I wanted to make was that whenever you start in a new place it is very important that we take on cases that are relatively safe and simple, where we are fairly certain we will have a good outcome, and not leaving patients with serious problems that need to be addressed when we leave the country.

Dr. Van Beek: That gets me right to the next point. We've learned that we have to plan the trip, we've learned that we have to be organized, we learned that there are language barriers that we have to solve. What about the issue of patient safety and team safety on mission trips? What do we define as a simple case?

Dr. Pirela-Cruz: Well that's a tough question. A lot of it depends on the experience of the surgeon and also what your capabilities are on the particular mission. Certainly it's defined by the resources that you have and whether or not you're going to have the after care, and the support that you're going to have from the host environment. So all these factors have to be taken into consideration. And we have actually said, "this is something we possibly could do somewhere else, but we really shouldn't take it on in this particular mission at this time". And so you have to make those critical decisions. But I would say again, until the people really get to know you, until you feel comfortable with the surroundings, it's good to err on the side of caution, and be very selective about which cases you take on. The worse thing in the world is to have some complicated case that you take and then you have a major disaster afterwards, I think that is really very troublesome for what you're trying to accomplish.

Dr. Van Beek: Warren, how do you go about screening patients to make sure you're not doing a complicated case or a case that you shouldn't do?

Dr. Schubert: Every time that I have gone on a surgical mission I have seen cases that I knew were over my head, or too complex for our anesthesiologists or nurses to manage. I have always had to turn away some cases.

Dr. Van Beek: What are the criteria for turning a patient away, because it's a very emotional thing for the patient and for the parents and actually for the team when you turn a patient away, so what criteria do you use to turn a patient away that it isn't safe to provide care?

WE SCREEN THE KIDS AS A GROUP. WE HAVE THE PEDIATRICIAN, THE ANESTHESIOLOGIST THE SURGEON, AND THE THERAPIST THERE. AND WE ALL HAVE TO AGREE THAT THIS IS A CASE THAT WE CAN TAKE ON.

MIGUEL PIRELA-CRUZ, MD

Dr. Schubert: If we see a case where you know it would need long term follow up, or would need diagnostic tools or a blood bank, or things that would make the surgery dangerous, we need to be willing to say "no". There is no blood bank where we work. If I see a patient with an AV malformation, which I might easily decide to do if I was in my home institution, but know that I would be pushing the limits of safety in a developing country, it is likely that the patient is going to be turned away.

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After we have gone to the same place for many years, the local physicians at the host institution have obtained a better idea of the surgical cases that we are comfortable in managing. Each year we have a smaller percentage of patients that we have to turn away.

In addition we have also worked with an organization, Partner for Surgery, that basically goes out and finds patients in the hinterlands. They send JPEG photos of the patients and sometimes you can pretty much tell from those photos whether the case is a patient you would operate on. If it appears that it is a case that we would not operate on, we give the patient the option of whether they would like to be seen in consultation. Sometimes we are able to help the patient in obtaining a referral to another surgical team or group of specialists.

Dr. Van Beek: Lynn, how about in hand therapy? When you travel with a surgical team, how do you go about screening patients to make sure that it's safe to operate on them with your teams?

Ms. Bassini: The more we go down the better the screening process has become, in terms of selecting cases that will be safe and receive the appropriate follow-up. The more we know of each case, and if there is the follow-up needed, the better this case is for us to operate. Follow up includes therapy, wound changes, xrays, MD visits, etc.

Dr. Van Beek: What type of hand cases would your team typically think would be safe to do on a mission trip to a foreign country?

Ms. Bassini: We do many scar and contracture releases, polydactyly, syndactyly.

Dr. Van Beek: Warren or Miguel, anything that you would add?

Dr. Pirela-Cruz: I think one thing that helps is that we screen the kids as a group. We have the pediatrician there, we have the anesthesiologist there, we have the surgeon, and we have the therapist there. And we all have to agree that this is a case that we can take on, and one we feel relatively comfortable with. We also have the doctors that are going to follow the patient after we leave. We don't proceed unless everyone agrees, and I think that helps tremendously. If we do, for example, a groin flap, we have to make sure that the physicians who are going to provide the aftercare and detach the flap feel totally comfortable with that, and know exactly what's going on. There may be some medical issues that the pediatrician will say "hey, look, this kid had a problem before, we probably shouldn't do this right now" – and then we won't proceed. These are the sort of things that we use to try to have a safeguard and help us with trying to be selective about the cases.

Dr. Van Beek: Is your screening day more or less your safety selection day?

Dr. Pirela-Cruz: Yes.

Ms. Bassini: The screening day is extremely important. This is the day of decision. Appropriate history is taken, the surgeons discuss the procedure to be done and who will do it, therapy is planned and post surgical care is discussed. The family and a local physician are also present. Many issues have to be determined and we are getting better at this, these include finances that will be needed once we are gone and family commitment to patient follow up. Appropriate documentation must be put in place.

Dr. Van Beek: Warren, how do you make sure there are resources for patient follow up ?

Dr. Schubert: First as to follow up, I'm in the boonies. There is no follow up. There is nobody interested or qualified in seeing these patients, and basically their follow up – if they have any – is when I go back the next year. This makes it critical, as I've mentioned before, to address the more simple surgical problems that still are important to the patients. Things like polydactyly, syndactyly, and some burn scar contractures are examples of relatively safe cases to take on. As to resources, we have emphasized people paying their own way. In addition, there is a minimal administrative fee for the nurses and other people, which comes to about $120. All of the surgeons pay $1000, and using these funds we pay our overhead. This overhead includes our expenses to the hospital, such as salaries for extra night nurses, anesthesia gases, IV fluids, medications, meals for the team, increases in hospital laundry, etc. My experience has been that when people have to fund their own travel, it often attracts a completely different caliber of people.

IF YOU'RE GOING TO A NEW SITE, THE RISKS ARE TENFOLD, AND YOUR ONLY PRAYER IS DOING A LOT OF GROUNDWORK... MEMBERS OF THE SITE VISIT SHOULD INCLUDE A SURGEON, AN ANESTHESIOLOGIST, AND A NURSE.

WARREN SCHUBERT, MD

Dr. Van Beek: Miguel, how do you handle the financial cost of your team?

Dr. Pirela-Cruz: Lynn sent me a beautiful outline of the cost and how much each patient costs. She's also very knowledgeable about the fundraising aspects, so I'll let her answer that one.

Dr. Van Beek: Can you give us an estimate of the cost to your organization to have, for example, one child have a burn scar contracture released?

Ms. Bassini: In regards to the funding, I am in regular contact with some of the doctors doing follow-up. We send money down for a particular case that may still need follow-up. They're not very large amounts so far. The cost per patient from screening day to surgery, therapy and follow-up averages $200-$250 per case. Our missions are also completely funded by our partici-

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pants – they pay for their hotel, air, and a small fee of $200 or $250 that is used for transportation within Guatemala. We do fundraising during the year. We do not have any big donors. Our average donation is between $50 and $100.

Some of our donations are used for the educational component of our mission. We offer a two-day bilingual conference to teach and share information regarding topics in hand surgery and therapy. Some missions will cost more than others, depending on the staff that we may bring. We have had to hire local anesthesiologists and nurses when we do not bring our own.

Dr. Van Beek: Thanks. Lynn, since you mentioned it, would you comment on the native language teaching materials that you use?

Ms. Bassini: Regarding the educational material that needs to be provided in Spanish, we translate as we go and write instructions in both languages. We keep a copy, and one copy stays in the chart. I have managed to get some books and journals in Spanish to donate—also a work in progress. We bring the local therapists and review protocols and patients.

Dr. Van Beek: What about teaching materials for the parents or for the people you're operating? For example, all the therapy protocols – do we have protocols in Spanish that we can give patients or their families who have hand surgery?

Ms. Bassini: We sit with the family, with a translator, and we write as much as we can to make it easier for them. We have developed forms in both English and Spanish.

Dr. Van Beek: What is the minimum that you would accept as a safe team for anesthesia in the operating room?

Dr. Pirela-Cruz: We like to have a pediatrician on board, someone who's going to initially help us with the screening of the child; a competent anesthesiologist; the surgeon; a circulating nurse ;, and the nurses in recovery – at a minimum I would say we need to have those bases covered to provide from the beginning to the end of the case. And then later on we also have to have the follow up, the aftercare; that's important too.

Dr. Schubert: Allen, I'd like to just add one thing to what Miguel said, especially for those who might be novices in doing this. The majority of deaths that I've heard about in Third World countries happen in the recovery room. For new people going down, the importance of having good recovery room nurses with you just cannot be overemphasized – especially if you take your own anesthesia people, because the way a lot of North Americans do anesthesia is not the way they do anesthesia in the Third World. North Americans are used to giving pain medicines such as morphine. We have all heard horror stories of how local nurses are used to caring for the babies that are crying, but not the ones that are silent. The silent child is noticed hours later with their pupils fixed and non respondent.

Dr. Van Beek: So, what do we need to have in the recovery room to have a safe recovery room?

Dr. Schubert: In addition to good nurses, pulse oximeters, suction, oxygen, and, ideally, if you're doing kids, pediatric recovery room nurses.

Dr. Van Beek: How do you see that, Miguel?

Dr. Pirela-Cruz: I agree. And it also helps to have a pediatrician on standby if need be, if there are some problems additionally.

Ms. Bassini: I have one more comment. The only casualties I have heard of have not been during hand surgery teams, but during a neuro mission. These occurred during the transporting of patients from the local hospital to a larger institution. There needs to be a working emergency plan that is in place and gets carried out. We need to make sure this is happening. Equipment needs to be appropriately maintained. I recall checking several times before coming down to make sure the sterilizer was working properly. I have been told that it is, and then, when we go down, it is not.

Dr. Van Beek: Do you think that a team should be operating on children in a facility that can't handle a pediatric emergency?

Ms. Bassini: The hospital that we operate in is, on paper, equipped to handle some emergencies. They have an ambulance ready to transport children to another facility. I need to make sure this is in place every time I go down. I also need to make sure that my team has a list of other local physicians who can help us if an emergency does occur.

AS SOON AS WE'RE DONE WITH ONE MISSION, WE START WORKING ON THE NEXT.

LYNN BASSINI, OTR, CHT

Dr. Van Beek: You think it's okay to operate in another facility as long as you have a pediatric center nearby and that you have made arrangements for ambulance transfer if something happens, is that correct?

Ms. Bassini: Yes.

Dr. Pirela-Cruz: I agree, but I will repeat that the surgeon and the whole team has to feel comfortable with the case that's being performed. Which means that in the event you do have an emergency, you have to feel comfortable being able to handle it, and provide the immediate needs. If that's not the case, then you really have to seriously consider re-planning the whole mission.

Dr. Van Beek: How do you handle a crisis on a trip? What does the team have to do to be prepared to handle

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a crisis? Let's say an event occurs, how does the team respond to that? Is that an important part of team planning?

Dr. Pirela-Cruz: It is, and a lot of the planning has to be done proactively. We have identified people and resources beforehand in the event we need something additional, so that we can turn to that individual to help us, get that piece of equipment or provide those additional services. It is extremely important to know what your resources are and who you can turn to, to get any additional help that you may need at the spur of the moment.

Dr. Schubert: A team should be thinking about preparing for 2 kinds of crises, and this is something that I have done an inadequate job of—both a crisis of one of your patients, and also a crisis of one of your team members. Each year my team is getting older. One of our nurses on one of our recent trips had terrible chest pain and hypotension and I was afraid she was having an MI.

We had never looked into what we would do if one of our team members had an emergency, and where we would take them or how we would get them out of the country. That's something teams should think more about.

Dr. Van Beek: What have your teams done to deal with the 220/120 voltage differential?

Ms. Bassini: That is an issue. Power failure and poor lighting is also an issue.

Dr. Pirela-Cruz: On one occasion, I was operating and the lights went out completely in the hospital. The only things that were working was the generator and the anesthesia machine, and we had this child asleep. We ended up having to finish the surgery by flashlight. It was really quite an experience.

Dr. Schubert: In the one facility in Guatemala we operate in, they have 220 volt and 120 volt plugs in the same room, with the same receptacle. We've lost a lot of good equipment by plugging the wrong one into the wrong receptacle. We usually try to have someone who's kind of a handyman come down now with the little volt tester and use duct tape over the 220 volt receptacles so we don't lose any more EKG or anesthesia machines. In Bolivia and Ecuador this has also been a problem. We have had to buy the most expensive transformers we can find, and you need an especially big one if you brought your own autoclave. The transformers weigh so much we usually leave them at the hospital when we leave.

Dr. Pirela-Cruz: We have on occasion ended up deferring all surgery until we had electricity. We bring battery operated headlights and make sure that our chargers will accept both 220 and 120, so you don't blow up your equipment.

Dr. Schubert: The other thing that's interesting is that some of the equipment that you have works for both voltages, but it has a switch in the back. Our laptop computers just plug in and they work with both. A lot of equipment representatives say their machines work with both voltage sources. Often they will only work if you throw the switch in the back before you plug it in. This switch is generally hard to find, poorly marked, and if improperly set, your equipment will be ruined during the first second you plug it in.

Dr. Pirela-Cruz: That's why whenever possible we try to take battery operated equipment. We always try to take batteries that we can charge, for example K wire drivers, drills and saws and that sort of thing, and that helps. You can travel relatively light, you don't have to worry about having to use any other kind of power source, and that really helps tremendously.

Dr. Pirela-Cruz: Lynn, can you tell us how many kids you take care of on an average mission?

Ms. Bassini: Sure. We may screen AT LEAST 100, and we operate on anywhere between 40 and 50 cases. Some of these cases of course, have multiple procedures. The therapists will evaluate and treat over 100 cases. We operate over 4 days. The fifth day is for rounds, follow up, packing and inventory.

Dr. Van Beek: And how many rooms are you running?

Ms. Bassini: Three rooms most of the time. We may get slowed down because of sterilizing, or patients or local staff not being ready.

Dr. Schubert: Do you have an anesthesiologist in each operating room? Do you have the anesthesiologist handling the recovery room when you run a bigger team?

Ms. Bassini: Yes, we have an anesthesiologist and/or anesthetist in each room.

Dr. Van Beek: What about medical records? Do you keep medical records, and what do you keep on your medical records, and why should we keep medical records from mission trips?

Dr. Schubert: Medical records in most third world countries are pretty scant by our standards. The place we go to regularly does keep a record of all of our orders and our brief written note. We have found that it is very useful having pre printed, bilingual preop and post op orders that can be easily checked off in a manner so that a physician or nurse from both countries can understand what the plan is. We have also devised similar forms for a short operative note.

Dr. Pirela-Cruz: We recently got a computer., We decided that we needed to keep our own records as well, and to have a database. We recognize the fact that we often see patients in follow up, and we need to refer back to the notes to remember what we've done, and so it is important to have good records that you can rely on.

Ms. Bassini: And I think we have really served as an example to

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them. Now that we go back year after year, their records have improved. When we wanted to do a follow up on our 2nd mission and I asked for the records, they had none. We use triplicates and also keep our own records in case we need to reach the patients. I have reached some cases myself. The plan is to have a program in our computer that will have the photos and follow-up of a patient year after year. That is why I have chosen to do this in only one country.

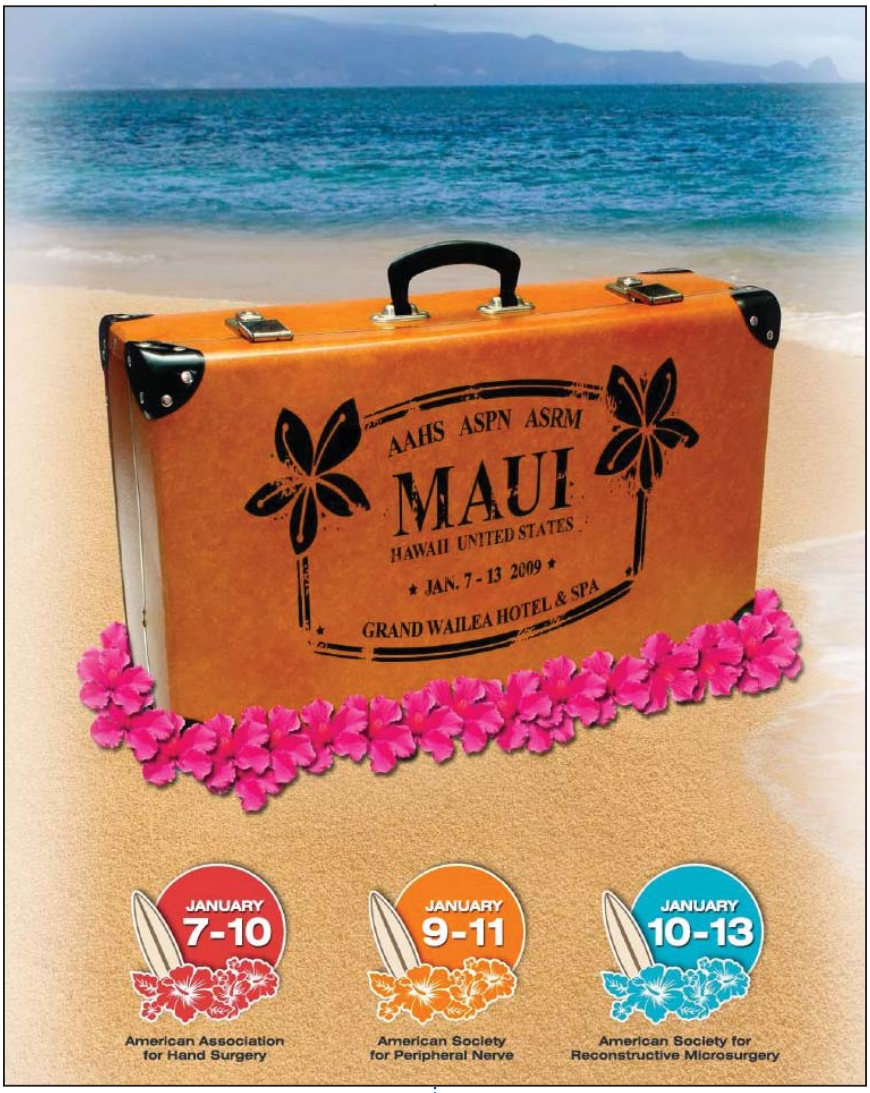
Dr. Van Beek: Do you bring your computer along and printer along? Is that a recommendation that we would make for teams?

Ms. Bassini: Yes, we bring our own computer. Several of us have computers in use during the screening process. At times this slows us down, but in the long run it is best to have documentation.

Dr. Pirela-Cruz: And we have a program that we developed to keep track of the patients.

Dr. Van Beek: One of the things I've encountered on trips is that sometimes the translators are not medical translators, and they don't get the appropriate translation. How do you deal with making sure that the translator is actually giving accurate information?

Dr. Schubert: This is a problem beyond belief in Guatemala and many other countries with a large indigent native population, where many patients' primary language is not the primary language of the country that you are working in. In these cases, in addition to the English-Spanish challenge, you have the challenge of making sure that a Spanish translator is appropriately translating into the appropriate Mayan dialect. The three language translation issue increases the odds of a misunderstanding by logarithmic proportions. A well trained North American medical translator who is not familiar with the culture and has not had experience working with a peasant population with little previous exposure to the outside world is in for a real challenge.



Dr. Pirela-Cruz: That reminds me of something that happened to me when I was in Guatemala. Some of the patients we were taking care of spoke Mayan Dialect. I would tell them when I would see them "come on in and have a seat", and in Spanish you would say 'como uno siento', and this patient looked at me in a puzzled kind of fashion and then the translator started laughing. I asked "what's going on?", and he said "well, do you know what you just told the patient? You told the patient come on in, and have some diarrhea!" Apparently "sientos", which means sitting down, is what they use to refer to diarrhea. It's mucho sientos. And I just sat there…

Ms. Bassini: Many times the translator turns out to be a 7 year old kid that speaks Spanish.

Dr. Pirela-Cruz: The problem is that the 7 year old kid speaks Spanish but doesn't understand medical terminology and that's sometimes a huge issue for us. We like to have medically fluent translators. You need to have translators that understand both the language and the implications of medical treatment.

Ms. Bassini: Usually the last person who is in touch with the family is the therapist, and a translator if needed (or me). That is where all things have to be in place, the post surgical orders, next MD or therapy

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HAND TABLE

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appointment, wound care if needed, exercises, meds, etc.

Dr. Van Beek: What about team personnel safety? What have you done for the potential unknown risk to exposure of hepatitis, aids and other potential infectious exposures?

Dr. Schubert: I'm not as worried about HIV as I am about Hep C. I know many surgeons who have Hep C, some who are no longer in practice, and some who are having serious health problems as a result of their illness. I know there's this big stigma about HIV, but I do not know any health care workers who contracted HIV as a result of their work.

Dr. Pirela-Cruz: I do know a resident who developed HIV from a needle stick, and it was really a sad situation.

Ms. Bassini: One of our volunteers in Guatemala had a needle stick recently.

Dr. Van Beek: Are you recommending that all your team members be immunized? Are you taking along immune globulin? Are you taking along anti-virals on your trips?

Dr. Pirela-Cruz: We really haven't addressed that issue adequately. Even when I've done my missions with the military, sometimes we go with very limited.

Dr. Van Beek: What about malignant hyperthermia? Do you take dantrium along?

Dr. Schubert: We used to have it, but it is very expensive and it expires quickly. We have an event with a child with previously undiagnosed malignant hyperthermia.

Our anesthesiologist had the direct phone number of a world expert at the Mayo Clinic. He stopped the problematic agents, kept the patient asleep and we packed him with cold beverage cans. After two hours of monitoring his temperature, PCO2 and urine output, we completed the operation, and the child did well. I don't believe we could have reliably found unexpired Dantrolin in the city we were working, nor in the capital city.

Dr. Pirela-Cruz: I remember starting a case and the kid had a little buccal spasm, and the anesthesiologist aborted the case right there. I asked what was going on, and he said, well, this kid has MH and we need to stop. And sure enough, later on we did some CK levels and they were sky high. So this also falls back on the experience of the individual and the physicians taking care of the kids. A lot depends on the experience of the anesthesiologist.

Dr. Van Beek: It's very interesting, because there's 3 surgeons here, and all 3 of us have had experiences with malignant hypothermia on our trips. So I think that malignant hyperthermia is a real issue and at some point in time you're going to see it.

Dr. Van Beek: Do you recommend trip insurance for your teams, or for individual team members, so if somebody is sick or injured and you had to Medivac them, you don't have to put it on your credit card? What are your thoughts about trip insurance?

Dr. Schubert: I think this is a good idea. As a team organizer I should be more strongly encouraging my team members to purchase this insurance. I think only one out of 30 of our team has it.

Dr. Pirela-Cruz: It's a good idea if they can do it, absolutely. But we don't routinely have our members do it.

Dr. Van Beek: I would recommend that you do have trip insurance for your group, and when you get group trip insurance it's more affordable than if asked each member to have it. What that usually means is maybe only 1 or 2 people could be transported back my Medivac. Medivac transport back out of almost any country is a $10,000 and that's a big ticket for a lot of teams.

ALEN: The last topic I wanted to cover was the topic of joining other

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organizations that go on trips. I know that there are orthopedic teams that go – what do you think about paralleling or joining with orthopedic and plastic surgery teams that are already funded and doing work other than hand surgery?

Dr. Pirela-Cruz: I think that'd be excellent Absolutely.

Dr. Van Beek: Give me the names of some of the orthopedic teams that you know of that others would be able to team with, because that's where I'm really going with this.

Dr. Pirela-Cruz: Well, Orthopedics Overseas is certainly the one that comes to mind, and they have a long track record and are a well-established group. There's also another group out of Houston. Also, on the military side, there are missions that I periodically get updates on that are looking for volunteers.

Dr. Van Beek: How do members that want to go on a trip get aligned or get joined up with these organizations? How do we go about getting them paired up with organizations that are doing trips?

Dr. Pirela-Cruz: Well I'd say the first thing is to try to find someone who's involved in it and ask them about the organization and try to see if you can find out if it actually coincides with what your interests are. Sometimes it may be a religious group, or it may be some other type of organization. Try first to ask questions and find out what they're about and how they're funded and the specifics of the mission. The more detail you get the better off you'll be educated on the actual mission.

Dr. Schubert: And to add to that, I think it's very important for people who organize trips to be very up front with their own team members as to where they're coming from regarding their beliefs, and why they are serving on a mission.

American Association for Hand Surgery Calendar

For information contact:
AAHS Central Office at 312-236-3307 or www.handsurgery.org

2009

January 7–10, 2009
39th Annual Meeting
Grand Wailea Resort
Wailea, Maui, HI

Feb. 25–Mar. 1, 2009
AAOS Annual Meeting
Las Vegas, NV

September 2–5, 2009
ASSH & ASHT Combined Annual Meeting
San Francisco, CA

October 7-9, 2010
ASSH Annual Meeting
Boston, MA

October 23–29, 2009
ASPS Annual Meeting
Seattle, WA

2010

January 6–9, 2010
40th Annual Meeting
Boca Raton Resort & Beach Club
Boca Raton, FL

October 1–6, 2010
ASPS Annual Meeting
Toronto, Canada

2011

January 12–15, 2011
41st Annual Meeting
Ritz Carlton Cancun
Cancun, Mexico

September 23–28, 2011
ASPS Annual Meeting
Denver, CO

Dr. Van Beek: What do you mean, "where they're coming from," Warren?

Dr. Schubert: There's nothing more awkward than to have someone whose main goal is to operate arrive at a mission and find out the main focus of the group they're with is religious. Or to have someone who thinks that it's a multi-denominational apolitical group and to find out that actually they're working very closely with some government official, the military, or some corporation.

There may be times when working with such groups may be appropriate, but this needs to be very transparent when you're organizing a mission, so that the entire team is all on the same page.

The term 'mission' and the intentions of missions can mean very different things to different people. It is fine to have team participants with different beliefs and backgrounds. But there will be more harmony with the team if indeed they have all agreed to the same mission.

Ms. Bassini: I really feel there should be total transparency as to the mission, including its funding. You need to have a good match between the volunteer and the mission.

Dr. Van Beek: How do we determine who can do hand surgery on a mission trip? Can a general orthopedist who hasn't done a lot of hand surgery, should he go on a hand trip? How do we screen our surgeons to make sure that we have the same level of care for a patient in an international country that we would have in our own country – or is that important?

Dr. Pirela-Cruz: Well it certainly is important to have a complement of people that everyone is comfortable with. Obviously a lot of times you don't find out the skills of the individual until you get down there. You may have someone who's capable of coming in and helping out whenever things go awry, or maybe they're just not familiar with it. And again doing the homework up front is very, very important. We need to know, when we screen the kids, who's going to do the surgery

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and that they feel comfortable with it. And if the surgeon says they don't feel comfortable with doing it but they would be willing to help someone else with the surgery, then that's fine. We work these things out up front, and this is what's important.

Dr. Schubert: I don't think there's anything to be ashamed of if a very competent surgeon takes someone who's interested in learning and helping, who may not be on the cutting edge, but basically will be there as an assistant. The days get long, many people get sick, and we all have had experiences where we've taken residents and fellows. Quite frankly when I die, the biggest contribution I could make is by having inspired other people to follow in my footsteps.

Dr. Van Beek: Panelists, each of you give me the 3 points that you would like all the readers to know about what you think is important for a mission trip. Lynn?

Ms. Bassini: First, don't try to go solo. Join a group. Second, do your homework, study the country, the team and the kind of patients that you may be facing. Ask yourself, is this where I want to be? Third, be honest with yourself. Is this for you? Otherwise, look for another group that may be a better fit for your interests, beliefs and talents.

Dr. Van Beek: All right, how about you, Warren?

Dr. Schubert: I agree with the points that Lynn made about considering what you are really trying to accomplish. Is the main focus teaching, to do assembly-line surgery to take care of as many patients as possible, or to provide a special experience for North Americans to see the way the rest of the world is?

Dr. Van Beek: So one of your points is to experience another culture?

Dr. Schubert: Be honest with yourself in deciding which of the three focuses is your true mission.

Dr. Van Beek: Miguel, what would be your three points?

Dr. Pirela-Cruz: Well I certainly agree with what has been said. I would certainly say that it's important on surgical missions to, really do your homework up front. The planning and energy you put in up front will certainly help in terms of success of the mission. That's the first point. The second point is to bring in the local surgeons to help you. They know the culture, they understand the individuals, they can really get you through a lot of the barriers that will be in place, and they can help you negotiate the terrain. You can learn as much from them as they can learn from you. The 3rd point is to start out slowly. Again, meaning to be very selective about the cases that you take onPick simple cases until you gain the confidence of everyone and everybody feels comfortable with each other. And that may take a day or two, or it may even take a mission or two before everyone starts to get a feel for what you're capable of.

Another point I'd like to make is that there's a lot to be gained from these missions. For example, I had an intern from Peru who spent some time up here in El Paso. He had an interest in hand surgery. I asked him how he got interested in hand surgery, and he said there was a doctor who would come down periodically to Peru and this is where he learned about hand surgery. I asked who was that, and he told me he was Dr. Van Beek. It's really amazing the influence that you have in what you do, and how you affect others.

Dr. Van Beek: I think those are all really great points. Is there anything we've missed that should be covered?

Ms. Bassini: I have three very quick points to make that we didn't get to cover. One is bringing some of the very involved kids to the United States. Dr. Pirela-Cruz and Dr. [Scott] Kozin have both operated on kids from Guatemala in the US. Another point concerns storing of supplies, or, if these are left behind, what happens to them. You do not want them to end up in some type of illegal market. Finally, I am concerned about the usage of expired medication or supplies.

Dr. Van Beek: It seems when you leave supplies behind, if you leave them with anybody other than the family, with very careful instructions, the family may not get the supplies. And so it's a huge issue. Even getting transportation for a return visit can be impossible for some families because of their economic status or location.

Ms. Bassini: Exactly.

Dr. Van Beek: Thanks everybody, this concludes our discussion tonight. At the January meeting I'm going to push hard to have AAHS align with the plastic surgery people to send hand surgeons on cleft lip and palate trips. The cleft lip and palate teams are all well funded and they're finding out the same thing that I'm finding out in trips—we're asked to do a lot more hands than we ever did before, because the clefts are getting taken care of because there're so many teams. And I'll ask your support for that one when the topic comes up. I think this discussion goes a long way in helping people understand what they're going to have to prepare for if they go on a trip. Most of the time, the logistics we talked about tonight are covered by really good teams. What isn't covered is providing a good, competent hand surgeon to go on the team to take care of some really significant congenital defects that I've seen, some severe, such as severe burn scar contractures, that just aren't being managed. So I hope this helps. H

AAHS Mentoring Program Volunteers

Below is a list of AAHS members who have generously offered to teach their expertise in specific areas, letting our members continue to learn the way we were taught, as residents and fellows, in the clinic and operating room with a surgical mentor. For more information, please contact the AAHS Central Office. H

NAME	EMAIL	PROCEDURE(S)
R. D. Beckenbaugh, MD	beckenbaugh.robert@mayo.edu	Technique of pyrocarbon arthroplasty of the thumb carpometacarpal; and metacarpophalangeal and PIP joints of the digits
Richard Berger, MD, PhD	berger.richard@mayo.edu	Wrist surgery
Kyle Bickel, MD	kbickel@sfhand.com	Vascularized bone graft reconstruction for carpal pathology; complex fracture management in the hand and wrist; and arthroscopic wrist ganlion excision
Allen Bishop, MD	bishop.allen@mayo.edu	Brachial plexus reconstruction; carpal vascularized bone grafts; and microvascular free tissue transfers
James Chang, MD	changhand@aol.com	Dupuytren's Contracture; thumb reconstruction; flexor tendon surgery; trapezial excision arthroplasty; and medial epicondylectomy
Kevin Chung, MD	kecchung@med.umich.edu	Rheumatoid and congenital
Tyson Cobb, MD	tycobb@mchsi.com	Endoscopic Cubital Tunnel Release
E. Gene Deune, MD	egdeune@jhmi.edu	Congenital hand anomalies; upper and lower extremity reconstruction for deficits due to trauma; cancer resecation; and neurological disorders (i.e. brachial plexus)
Scott H. Kozin, MD	SKOZIN@shrinenet.org	Pediatrics
Don Lalonde, MD	drdonlalonde@nb.aibn.com	Wide awake approach to hand surgery
W. P. Andrew Lee, MD	leewp@upmc.edu	Post traumatic hand reconstruction; mini incision carpal tunnel release
Susan Mackinnon, MD	mackinnons@wustl.edu	Ulnar nerve surgery
Nash Naam, MD	drnaam@handdocs.com	SLAC wrist reconstruction; vascularized bone graft in treating scaphoid nonunions; ulnar shortening & radial shortening; PIP & MP joint arthroplasty; LRTI; arthroscopy of the CMC joint of the thumb
Daniel J. Nagle, MD	OOGIEN@aol.com	Wrist arthroscopy; endoscopic carpal tunnel release
Michael Neumeister, MD	mneumeister@siumed.edu	Basilar joint arthroplasty; peripheral nerve decompression
Jorge Orbay, MD	jlorbay@aol.com	Wrist fractures
A. Lee Osterman, MD	loster51@bellatlantic.net	Advanced wrist arthroscopy and small joint arthroscopy. Can also mentor a topic such as DRUJ problems, or wrist fracture.
Julian J. Pribaz, MD	jpribaz@partners.org	Soft tissue reconstruction; microsurgical reconstruction; spare parts surgery and extremity reconstruction
Michael Raab, MD	mikeraab1@earthlink.net	Corrective osteotomy (volar or dorsal) of distal radius malunion with iliac crest bone grafting
Jaiyoung Ryu	jryu@adelphia.net	Wrist reconstruction; distal radius fracture; and scaphoid fracture/nonunion
David Slutsky, MD	d-slutsky@msn.com	Use of volar wrist portals for wrist arthroscopy and arthroscopic repair of dorsal radiocarpal ligament tears; nonbridging external fixation of intra-articular distal radius fractures; nerve conduction studies for hand surgeons; and comparison of NCS and PSSD for the diagnosis of CTS
William Swartz, MD	william.swartz@verizon.net	Tendon transfer and ulnar nerve
Thomas Tung, MD	tungt@wustl.edu	Brachial plexus and nerve transfers
Joseph Upton, MD	jupton3@earthlink.net	Congenital hand surgery
Elvin Zook, MD	ezook@siumed.edu	Fingertip reconstruction