

Winter  
2015

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# HAND SURGERY

Q U A R T E R L Y

## MESSAGE FROM THE PRESIDENT

In a month I hope to see you all a little sun-burned, relaxed and enjoying our annual meeting at the Atlantis in Nassau. Tom Hughes, Chris Novak, Kristin Valdes and their program committee reviewed a record number of submissions. They have selected 112 papers for oral presentation and 176 E-posters.

Interspersed throughout the meeting we have 30 instructional courses with topics ranging from scaphoid fractures to tendon injuries and a session on "Social Media and Your Practice: Why You Must Participate and How to Stay Out of Trouble."

On Wednesday, Jane Fedorczyk will open Specialty Day with her invited ASHT Presidential

Lecture: "Embracing Technology In Hand Therapy". Mike Hayton, hand consultant for multiple professional soccer and rugby teams in the UK, will give his strategies on accelerated return to play.

Following the opening ceremony on Thursday, Lee Osterman and an all-star cast will open the annual meeting with "911 Complications – When Bad Things Happen to Good People".

My presidential address is titled "It's All About Harmony" which will explore how we can band together to provide care in ways that are safe, less expensive and less wasteful. Later that afternoon, Amy Ladd and Julie Adams will lead a session including an international gathering of



Mark E. Baratz, M.D.

preeminent women hand surgeons called "Love's Labor not Lost: Perspectives on Life and Career."

On Friday, Scott Kozin will give the Danyo Lecture on "Volunteerism-A Way to Shape the Global Community." If you had the chance to see his Presidential Address at the ASSH, you know this will be an moving presentation that will likely change the way you see yourself contributing to hand problems worldwide.

(continued on page 5)

January 21-27, 2015  
ATLANTIS  
PARADISE ISLAND, BAHAMAS

2015 ANNUAL MEETINGS  
AAHS ASPN ASRM

**DETAILS INSIDE....**

- January 21-24, 2015**  
American Association for Hand Surgery
- January 23-25, 2015**  
American Society for Peripheral Nerve
- January 24-27, 2015**  
American Society for Reconstructive Microsurgery



# 2015 AAHS ANNUAL MEETING

January 21-24, 2015  
ATLANTIS  
PARADISE ISLAND, BAHAMAS

In Collaboration with  
**BSSH** The British Society for  
Surgery of the Hand

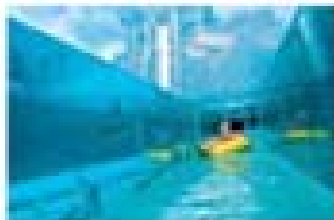
## Wednesday, January 21, 2015

- 6:30-8:00 Continental Breakfast
- 7:00-8:00 **Instructional Courses**  
Who Needs Therapy and Who Doesn't:  
Practical Applications to Optimize Outcome  
Raynaud's & Cold Sensitivity - Is There a  
Solution?  
Treatment Options For Finger Arthritis  
Shoulder & Elbow Assessment  
Fragility Fractures  
Scaphoid Fractures  
CMC Osteoarthritis  
Dupuytren's Disease  
Maximizing Economics in a Changing Health  
Care Environment
- 8:15 **President and Program Chairs Welcome**
- 8:40 **Invited ASHT President**
- 8:55 **Vargas Award Presentation**
- 9:00 **Panel: Hand Injuries in Athletes: From the  
Weekend Warrior to the Professional Athlete**
- 10:00 **Coffee Break**
- 10:30 **Panel: Hand Surgery and Therapy Tips & Pearls  
to Optimize Patient Outcomes**
- 11:30 **Invited Guest Lecture: Michael Hayton, MD  
When Can I Play Doc?**
- 12:30-4:30 **Hands-On Therapist Development Workshop:  
Elastic Taping**
- 12:30-5:00 **Hands-On Surgeon Development Workshop**
- 5:00-6:00 **Mentors Reception**
- 6:30-8:00 **Welcome Reception in Exhibit Hall**

## Thursday, January 22, 2015

- 6:30-8:00 Continental Breakfast with Exhibitors
- 6:30-8:00 **MOC Instructional Course: Carpal Tunnel**
- 7:00-8:00 **Instructional Courses**  
Unhappy Patients: Poor Outcomes and Dealing  
with Adverse Events  
Practice Management in the 21st Century  
Complex Wrist Fractures: Beyond the Volar Plate  
Soft Tissue Coverage  
Beyond the Z Plasty: Closing and Opening  
Gaps in the Pediatric Hand  
Ulnar Sided Wrist Pain: A Treatment Algorithm  
Hand Surgery Research: How, Where, and Why  
How to Approach Complex Elbow Trauma
- 8:15 **Presidential & Program Chairs Welcome**
- 8:20 **BSSH President Welcome**
- 8:30 **Panel: 911 Complications - When Bad Things  
Happen to Good People**
- 9:15 **Presidential Address: Mark E. Baratz, MD  
It's All About Harmony**
- 9:45 **Invited Guest Speaker: Charles J. Limb, MD  
The Neuroscience of Musical Creativity**
- 10:30 **Coffee Break with Exhibitors**
- 11:00 **Concurrent Scientific Abstract Sessions I & II**
- 12:15 **Concurrent Scientific Abstract Sessions III & IV**
- 1:30-3:00 **Industry Lunch Symposia**
- 3:00-5:00 **Hands-On Skills Labs**
- 3:00 -5:00 **Love's Labor Not Lost: Perspectives on  
Life and Career**

Hand  
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# Annual Meeting Program (continued)

## Friday, January 23, 2015

- 6:30-8:00 Continental Breakfast with Exhibitors
- 6:30-8:00 MOC Instructional Course: Metacarpal Fracture
- 7:00-8:00 **AAHS/ASPNI Instructional Courses**  
Tendon Repair - Optimizing Outcomes  
A Multidisciplinary Approach to Complex Trauma  
Poor Outcome After Fracture Surgery... Now What?  
Exploring Options in the Management of Scapholunate Instability  
Wrist Arthroplasty: What Works and What Doesn't  
Targeted Reinnervation for UE Prostheses: Motor Control & Sensory Feedback  
Denervation of Hand Joints for Pain  
Ultrasound and MRI in Nerve Injury
- 8:10 **Hand Surgery Endowment (HSE) Report**
- 8:20 **HAND Journal Update**
- 8:30 **Annual Business Meeting**
- 9:15 **Danyo Lecture: Scott Kozin, MD**  
Volunteerism - A Way to Shape the Global Community
- 10:00 **Coffee Break with Exhibitors**
- 10:30 **Concurrent Scientific Abstract Session V**
- 10:30 **Concurrent AAHS/ASPNI Scientific Abstract Session VI**
- 11:30 **AAHS/ASPNI Joint Invited Speaker**  
Susan E. Mackinnon, MD  
Pathway to Innovation in Academic Surgery: The Good, The Bad and The Ugly
- 12:30 **Lunch with Exhibitors**
- 1:30 -4:30 **Nerve Transfers: Distal Ulnar, Radial & Median Nerve**
- 1:30-5:30 **Comprehensive Hand Review Course**
- 7:00 -10:00 **Annual Meeting Dinner Dance**

## ATLANTIS ACTIVITIES

The Atlantis Resort features a variety of activities for “kids” of all ages, including Dolphin Cay, waterslides, water rides, beaches, swimming pools, championship golf, Mandara Spa, rock climbing, Atlantis Theatre, Yacht & Fishing Charters, a Casino, 21 restaurants, and 19 bars and lounges.

## Saturday, January 24, 2015

- 6:30-8:00 Continental Breakfast with Exhibitors
- 6:30 -7:30 **AAHS/ASPNI/ASRM Instructional Courses**  
Medical Missions: Pearls & Pitfalls  
Social Media and Your Practice: Why You Must Participate and How to Stay Out of Trouble  
Upper Limb Nerve Compressions  
Your Nerve Transfer Didn't Work, What Next?  
A Critical Appraisal of the use of Avance Nerve Allograft  
Getting the Most out of the Reconstructed Mutilated Hand: Microsurgery and Prosthetics  
Facial Re-Animation: State Of The Art Results, Success and Problems in Lymphatic Surgery: Lessons from Consecutive Cases
- 7:45 **AAHS/ASPNI/ASRM President's Welcome**
- 8:00 **AAHS/ASPNI/ASRM Combined Panel: The Affordable Care Act and its Impact on the Surgeon**
- 9:30 **Coffee Break with Exhibitors**
- 10:00 **Joint Presidential Keynote Lecture:**  
Ramez Naam  
Piercing the Veil: The Frontiers of Neural Prosthetics
- 11:00 **AAHS/ASPNI/ASRM Joint Outstanding Papers**
- 12:00 **Adjourn**
- 7:00 -8:30 **ASPNI/ASRM Welcome Reception**

### COMPLIMENTARY GUEST/SPOUSE REGISTRATION

As you finalize your plans for the Annual Meeting, remember that AAHS is again offering complimentary registration for AAHS Members' spouses/guests and children.

AAHS Members are encouraged to bring a spouse/guest and children to enjoy the Annual Meeting at the Atlantis Resort, a family-friendly destination full of adventure and discovery.

Please refer to “additional registration categories” to select complimentary spouse/guest/child rates when registering online or using the registration form.

Spouse/guest/child registration includes:

- ♦ Continental breakfast Wednesday, January 21st through Saturday, January 24th
- ♦ Attendance at the AAHS Welcome Reception in the exhibit hall on Wednesday, January 21st
- ♦ Attendance at the AAHS Banquet on Friday, January 23rd

## FROM THE EDITOR



**Thomas Hughes, MD**

As the year comes to close, it is an opportunity to reflect on the accomplishments of the past year. For the AAHS, this has been a productive year. Our new webinar series has been successful, kicking off with a webinar on Hand Trauma moderated by Lee Osterman and followed by Scott Kozin moderating a webinar on Pediatric Hand Trauma. The schedule for next year will begin with a webinar on February 9th covering flexor tendon injuries.

These webinars are a new endeavor for the AAHS and hopefully members will make use of the educational content contained within. They are a great opportunity to learn about a combination of complex and routine topics. They are sched-

uled in the late evening in order to impact your practice as little as possible.

Other notable achievements include the success of the Hand Surgery Endowment's "Hands At Work Project". The *Hands at Work Project* has been an attempt to raise the endowments capital to \$1,000,000. Through the generous efforts of many of our members, the fund has grown to \$875,000. We are only 13% away from our goal. The AAHS leadership had hoped to reach this goal by the end of the 2015 annual meeting, so please consider a donation if you have not already given. With the help of a generous donation from Dr. Rob Spinner, there is an opportunity to have your hands photographed by Dr. Javed Siddiqi. Dr. Siddiqi has published a book of neurosurgeon's hands entitled "*In Their Hands*" and he will bring his photographic skills to the Bahamas on January 23-24.

Finally, the AAHS has partnered with the ASSH on surgical outreach missions in

Haiti and Guatemala this past year. These missions have had a profound impact on both the people of Haiti and Guatemala as well as on the volunteers that provided the care. For those coming to the Annual Meeting in the Bahamas, Scott Kozin will discuss these outreach programs in his Danyo lecture "Volunteerism – A Way To Shape The Global Community".

So, as you can see, the AAHS has had another productive year. Our membership continues to grow and this year's annual meeting looks to be one of the best ever attended. Hopefully, you will have the opportunity to join us next January to celebrate and look ahead to the accomplishments of the next several years for the AAHS.

### HAND SURGERY Quarterly

#### President

Mark E. Baratz, MD, FACS

#### Editor

Thomas Hughes, MD

#### Managing Editor

Lorraine M. O'Grady

*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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**Make a pledge to the Hand Surgery Endowment's *Hands at Work Project* and have your hands professionally photographed in the Bahamas this January!**

Pollex and Digiti Secundus Manus level pledgees will have professional photographs of their hands captured by Dr. Javed Siddiqi on Friday, January 23<sup>rd</sup> and Saturday, January 24<sup>th</sup>. Dr. Siddiqi is a neurosurgeon at Desert Regional Medical Center's Institute of Clinical Orthopedics & Neurosciences, and author/photographer of *In Their Hands*, a book of photography featuring the hands of top neurosurgeons from around the world.

If you are interested in making a pledge to the Endowment and having your hands photographed along with an elite group of hand surgeons and therapists, please visit the [HSE website](#) for details and to submit your charitable gift.

*Note the HSE is a 501c(3) entity and all monetary contributions made to the Endowment are tax deductible.*

## PRESIDENT'S MESSAGE *(continued from page*

The last session in the morning will be the AAHS/ ASPN Joint Invited Speaker Susan Mackinnon. Her lecture is titled "Pathway to Innovation in Academic Surgery: The Good, The Bad and The Ugly."

Friday afternoon we have the Comprehensive Review Course chaired by Sanjeev Kakar and Alex Speiss. Susan Mackinnon and Chris Novak will chair a symposium on Nerve Transfers.

On Saturday we have the combined session of the AAHS, ASPN and ASRM. The morning begins with the combined panel on "The Affordable Care Act and its Impact on the Surgeon."

The combined societies guest speaker is Ramez Naam a brilliant writer and speaker who is the son of our own, beloved Nash Naam, current president of ASPN. I've read four of Ramez' books, both fiction and non-fiction. They are mind-bending. Paramount Pictures recently picked up his novel Nexus. His Joint Presidential Keynote Lecture is "Piercing the Veil: The Frontiers of Neural Prosthetics." Don't miss it!

I hope this gathering is

remembered as the meeting that rocked. The opening ceremony begins with a performance by the drum line of an award-winning local high school marching band.

The Steve Lee Band will rock the Mentor's reception. Just prior to the Presidential Address, Jason Rovak will accompany harmonicist PC Ho. Guest speaker, Charles Limb will show us how the brain looks when a musician gets creative. The Sagittal Band will play for the Presidential Reception. Finally, the Nassau band Ambassah with guest hand surgeon musicians, will party with us at the Friday night gala.

I leave you with exciting news. Through the efforts of Scott Kozin the ASSH has committed \$1,000,000 to the "Touching Hands Project". At the same time our organization has built a corpus of \$875,000 in our Hand Surgery Endowment as part of our "Working Hands Project". Our goal is to raise \$1,000,000 by the close of the annual meeting.

The "Working Hands Project" was conceived to support global hand health

***Through the combined efforts of the AAHS and ASSH we are close to devoting \$2,000,000 to improving hand care around the world. I believe that this is largest commitment to global hand care by a non-governmental concern in history.***

including the "Touching Hands Project" by providing scholarships to surgeons and therapists to participate in these outreach programs. Through the combined efforts of the AAHS and ASSH we are close to devoting \$2,000,000 to improving hand care around the world. I believe that this is largest commitment to global hand care by a non-governmental concern in history. Be part of this. Contribute to the Hand Surgery Endowment. Consider volunteering for an outreach program.

See you in Nassau.

## Hand Surgery Endowment

Thanks to the generosity of AAHS members, the Hand Surgery Endowment is now less than 15% away from its fundraising goal of \$1,000,000.

*As 2014 comes to a close and you are considering your holiday and year-end charitable contributions, please keep the HSE in mind and considering making a donation or pledge to supports its mission to promote global hand health.*

Details on the [Hands at Work](#) Project and programs which HSE dollars support may be found on the [Endowment website](#).

**[Make your holiday or year-end donation or pledge.](#)**

# HAND THERAPISTS CORNER:

## Pain Guided Hand Therapy for Hand Fractures: The Saint John Protocol

Donald Lalonde MD, FRCSC and Amanda Higgins BSc. OT

### Introduction

Early controlled mobilization of tissues surrounding a healing fracture has the potential to enhance the quality and rate of fracture healing and the functional range of motion of the hand<sup>1</sup>. Early mobilization has certainly been accepted for flexor tendon repair; it is one of the few things the Cochrane review on this subject has been able to support<sup>2</sup>.

The risk of tendon rupture has not dampened the interest in early protected movement for flexor tendon repair because of the fact that a stiff finger is a useless finger<sup>3,4</sup>. The loss of finger fracture reduction is a much easier thing to repair than a ruptured tendon.

The following protocol of early protected movement for finger fractures has been developed over many years in our unit with good success in terms of patient functional range of motion, patient satisfaction, and surgeon satisfaction. It has resulted in supple fingers and avoided stiffness. Very little loss of fracture reduction has occurred. It is based on two guiding principles:

**1. Early protected movement is just as important in finger and metacarpal fractures as it is in flexor tendon repair for the same reason; stiff fingers are not an acceptable good result.** The risk of clinically significant loss of fracture reduction with this protocol has been lower than the risk of tendon rupture in early protected movement with flexor tendon repair in our experience.

**2. The best guide to early pro-**

**tected movement which allows maintenance of fracture reduction is for the patient to be off of all analgesics to let his pain tell him what he can or cannot do.** The following is what we tell our patients: they mostly are very understanding of the concept. "We did not spend two billion years evolving pain because it is not good for us. It is nature's only way for our bodies to tell us: "Hey, don't do that; I'm trying to heal in here!". Get off of all pain killers including acetaminophen and ibuprophen as soon as possible, and let your pain tell you what you can and cannot do. Your body is very clever and it will let you know when you are pushing it. If you listen to your body, you will get better faster"

### 1. Distal Phalanx Fractures and Tuft Fractures

**Can be unfixated or K-wire fixated.** If there is a K wire, determine when k-wire needs to be removed with surgeon. K wire is usually removed when the fracture is no longer tender to palpation with the patient off all analgesics.

*Early protected movement is just as important in finger and metacarpal fractures as it is in flexor tendon repair for the same reason; stiff fingers are not an acceptable good result.*

There is not much point in moving fractures in the first 2-3 days after injury as collagen formation does not start until day 3, and because very early movement will cause bleeding which will generate more scar and callus.

Treat edema with Coban until the finger is no longer swollen

**Let the pain of the fracture be the main guide** in the healing phase for allowing movement unless the patient is unreliable. No movement is allowed while the patient is on analgesics and the hand is kept elevated. With the patient completely off of all analgesics, he is allowed to move it but he is not allowed to use it. If he does something that hurts significantly, he should not try that again for 2-3 days. When it no longer hurts to move it, he can use it. Don't baby it but don't do what hurts is the main rule.

If the fracture is unstable or if unsure when to start ROM, discuss with surgeon.

**If there is no K wire in stable distal phalanx fracture,** splint DIP in extension until the pain is gone. Take off splint and start active flexion of both DIP and PIP when patient is off analgesics, when he is just moving it but not using it stressfully in activities of daily living, and when it does not hurt him to move it. The pain guides the movement. Splint DIP joint during possible stress activities of daily living and during sleep. Keep the MP and PIP moving. Splint is no longer required when it no longer hurts to use the finger. The usual splinting time is 2-4 weeks.

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- **If K wire is across the DIP joint**, keep DIP extension splint on until the K wire is removed to prevent DIP flexion. Start active flexion of MP and PIP as soon as patient is off analgesics, when he is just moving it but not using it stressfully in activities of daily living, and when it does not hurt him to move it. The pain guides the movement.

- **If K wire is only in distal phalanx and not across DIP joint**, take off splint and start active flexion of both DIP and PIP (as well as MP) when patient is off analgesics, when he is just moving it but not using it stressfully in activities of daily living, and when it does not hurt him to move it. The pain guides the movement. Splint DIP joint during possible stress activities of daily living and during sleep. Splint is no longer required when it no longer hurts to use the finger. The usual splinting time is 2-4 weeks.

- Once splint is discontinued teach active ROM exercises (active composite fist and tuck, isolated blocking joint flexion and extension exercises) 10 reps every waking hour.

- When the fracture is solidly healed, usually at 6-10 weeks, forceful very frequent passive and active movement (several times

per hour with sustained holding and the patient counting to 10) to get the last few degrees of ROM can be initiated. At this point, pain is allowed as it is no longer the pain of fracture fragments moving, but it is the pain of stretching shortened ligaments. If frequent forceful active movement is not gaining after 4 weeks, passive forces can be applied.

- If non-union of fracture, may need to continue full time splinting for 6 weeks or longer.

- Nail bed injuries should be checked by surgeon at 6 weeks (if not already arranged sooner)

- Difficult to know if nail is going to grow at all or right for 6-9 months. If unsure bring patient back to surgeon at 6-9 months post injury.

## 2. Middle Phalanx Fractures

- **Can be unfixated or K-wire fixated.** If there is a K wire, determine when k-wire needs to be removed with surgeon. K wire is usually removed when the fracture is no longer tender to palpation with the patient off of analgesics.

- There is not much point in moving fractures in the first 2-3 days after injury as collagen formation does not start until day 3, and because very early movement will cause bleeding which will generate more scar and callus.

- Treat edema with Coban until the finger is no longer swollen

- **Let the pain of the fracture be the main guide** in the healing phase for allowing movement unless the patient is unreliable. No movement is allowed while the patient is on analgesics and the hand is kept elevated. With the patient completely off of an-

algesics, he is allowed to move it but he is not allowed to use it. If he does something that hurts significantly, he should not try that again for 2-3 days. When it no longer hurts to move it, he can use it. Don't baby it but don't do what hurts.

- If the fracture is unstable or if unsure when to start ROM, discuss with surgeon.

- **If stable fracture with no K wire**, then buddy tape finger to neighboring finger and start early active ROM when patient is off analgesics, when he is just moving it but not using it stressfully, and when it does not hurt him to move it. The pain guides the movement. Buddy tape until no longer sore to use the finger which is usually 2-3 weeks. Reassess the patient at 7 days to be sure there is still no unacceptable rotation (scissoring) or angulations. Continue with active ROM exercises, 10 reps every waking hour. If gains are not happening with active ROM, add passive ROM exercises at 4 weeks.

- **If unstable fracture or K wired fracture**, safest is to elevate hand and splint PIP and DIP in extension until the fracture is no longer hurting with gentle finger movement with the patient off analgesics (usually 3-10 days). When it no longer hurts to do so, actively move either or both of PIP and DIP joints as much as possible while stabilizing the proximal and/or middle phalanges with the fingers of the other hand or with a splint as guided by the patient's pain with movement. The patient is allowed to do this movement frequently (up to hourly) as long

*With the patient completely off of analgesics, he is allowed to move it but he is not allowed to use it. If he does something that hurts significantly, he should not try that again for 2-3 days.*

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as 1) he is off all analgesics, 2) he is just moving it but not using it stressfully with activities of daily living, and 3) it does not hurt him to move it. The pain guides the movement. Keep the MP moving at all times. Try to get as much ROM as possible at one or both IP joints as determined by the pain to keep the tendons gliding but not to move the fracture. (Like early protected movement in flexor tendon repair to keep the tendon moving but not to cause rupture). The PIP and/or DIP are splinted in extension during possible stress activities of daily living and during sleep, depending on the pain. Reassess the patient at 7 days to be sure there is still no unacceptable rotation (scissoring) or angulations. Splint is no longer required when it no longer hurts to use the finger, which is usually 2-4 weeks. It may be that intermittent splinting described above will only need to immobilize either the PIP or DIP only (as opposed to both joints), as guided by the patient's pain. Avoid excessive k-wire movement when performing active ROM to a joint. If a K wire site or finger looks infected, notify the surgeon. When the K wires are out, continue with active ROM exercises, 10 reps every waking hour. If gains are not happening with active ROM, add passive ROM exercises at 4 weeks.

**Subluxated intraarticular fractures of the PIP are all individual and will require surgeon guidance.** This may require a Schenk, Banjo, or other distraction splint. Surgeon will let you know. K-Wire will pass through middle phalanx distal to the fracture site. You will fabricate banjo splint to hook onto this k-wire and patient will usually wear this splint full

time x 6 weeks. Bring back to clinic for 6 week follow up (if not seen earlier). Helpful to have either x-ray or fluoroscan of reduction at 1 week to ensure adequate joint space with traction splint.

**Non Subluxated volar plate fracture avulsion injuries** do not require immobilization. They are buddy taped to an adjacent finger to prevent hyperextension recurrence for 3 weeks and they are Coban taped until no longer edematous. Coban acutely and start active composite fist and tuck exercises by 2-3 days after injury.

**When the fracture is solidly healed**, usually at 6-10 weeks, forceful very frequent active movement (several times per hour with sustained holding and the patient counting to 10) to get the last few degrees of ROM can be initiated. At this point, pain is allowed as it is no longer the pain of fracture fragments moving, but it is the pain of stretching shortened ligaments. If frequent forceful active movement is not gaining after 4 weeks, passive forces can be applied.

If flexion contracture at PIP occurs start night extension splint to correct. However, unless there is a boutonniere ruptured central slip, full flexion is more important than full extension.

### 3. Proximal Phalanx Fracture

**Can be unfixated or k-wire fixated.** If there is a K wire, determine when k-wire needs to be removed with surgeon. K wire is usually removed when the fracture is no longer tender to palpation with the patient off of analgesics.

*If a K wire site or finger looks infected, notify the surgeon.*

*When the K wires are out, continue with active ROM exercises, 10 reps every waking hour. If gains are not happening with active ROM, add passive ROM exercises at 4 weeks.*

There is not much point in moving fractures in the first 2-3 days after injury as collagen formation does not start until day 3, and because very early movement will cause bleeding which will generate more scar and callus.

Treat edema with Coban until the finger is no longer swollen

**Let the pain of the fracture be the main guide** in the healing phase for allowing movement unless the patient is unreliable. No movement is allowed while the patient is on analgesics and the hand is kept elevated. With the patient completely off of analgesics, he is allowed to move it but he is not allowed to use it. If he does something that hurts significantly, he should not try that again for 2-3 days. When it no longer hurts to move it, he can use it. Don't baby it but don't do what hurts.

If the fracture is unstable or if unsure when to start ROM, discuss with surgeon.

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· **If stable fracture with no K wire**, then buddy tape finger to neighboring finger and start early active ROM when patient is off analgesics, when he is just moving it but not using it stressfully in activities of daily living, and when it does not hurt him to move it. The pain guides the movement. Buddy tape until no longer sore to use the finger which is usually 2-3 weeks. Reassess the patient at 7 days to be sure there is still no unacceptable rotation (scissoring) or angulations.

· **If unstable fracture with no K wire, or fracture with a K wire**, safest is to elevate hand and splint MP in flexion and PIP in extension until the fracture is no longer hurting with gentle finger movement with the patient off all analgesics (usually 3-10 days). If there are no K wires across joints, actively move any or all of the MP, PIP and DIP joints as much as possible while stabilizing the proximal and/or middle phalanges with the fingers of the other hand or with a splint as guided by the patient's pain. The patient is allowed to do this movement frequently (up to hourly) as long as 1) he is off all analgesics, 2) he is just moving it but not using it stressfully with activities of daily living, and 3) it does not hurt him to move it. The pain guides the movement. Splint the MP and/or PIP joints during possible stress activities of daily living and during sleep. Reassess the patient at 7 days to be sure there is still no unacceptable rotation (scissoring) or angulations. Splint is no longer required when it no longer hurts to use the finger, which is usually 2-4 weeks, post injury or reduction. It may be that the intermittent splinting described above will only need to

immobilize one of the MP or PIP joints (as opposed to both joints), as guided by the patient's pain. The DIP should always be kept actively moving from day 2-3 on-

*Let the pain of the fracture be the main guide in the healing phase for allowing movement unless the patient is unreliable. No movement is allowed while the patient is on analgesics and the hand is kept elevated.*

ward to keep at least profundus gliding. Continue with active ROM exercises, 10 reps every waking hour. If gains are not happening with active ROM, add passive ROM exercises at 4 weeks.

· **Subluxated intraarticular fractures of the MP or PIP are all individual and will require surgeon guidance.** This may require a Schenk, Banjo, or other distraction splint. Surgeon will let you know. K-wire will pass through the head of the middle phalanx distal to the fracture site. You will fabricate banjo splint to hook onto this k-wire and patient will usually wear this splint full time x 6 weeks. Bring back to clinic for 6 week follow up (if not seen earlier)

· **When the fracture is solidly healed**, usually at 6-10 weeks, forceful very frequent active movement (several times per hour with sustained holding and the

patient counting to 10) to get the last few degrees of ROM can be initiated. At this point, pain is allowed as it is no longer the pain of fracture fragments moving, but it is the pain of stretching shortened ligaments. If frequent forceful active movement is not gaining after 4 weeks, passive forces can be applied.

#### 4. Metacarpal Fracture

· **Can be unfixated or k-wire fixated.** If there is a K wire, determine when k-wire needs to be removed with surgeon. K wire is usually removed when the fracture is no longer tender to palpation with the patient off of analgesics.

· There is not much point in moving fractures in the first 2-3 days after injury as collagen formation does not start until day 3, and because very early movement will cause bleeding which will generate more scar and callus.

· Treat edema with Coban until the finger is no longer swollen. May also need Elastogrip for swelling in back of hand.

· **Let the pain of the fracture be the main guide** in the healing phase for allowing movement unless the patient is unreliable. No movement is allowed while the patient is on analgesics and the hand is kept elevated. With the patient completely off of analgesics, he is allowed to move it but he is not allowed to use it. If he does something that hurts significantly, he should not try that again for 2-3 days. When it no longer hurts to move it, he can use it. Don't baby it but don't do what hurts.

· If the fracture is unstable or if unsure when to start ROM, discuss with surgeon.

(continued on next page)

· **Stable or unstable 2<sup>nd</sup> through 5<sup>th</sup> metacarpal fractures with or without K wire**, Until pain is gone and analgesics discontinued, elevate hand and resting hand splint or ulnar gutter splint with CMC and MP joints in a position of comfort, and which allows PIP and DIP joints free movement (usually 3-10 days). *MP flexion is no longer required since level I study (Hofmeister EP, Kim J, Shin AY. Comparison of 2 methods of immobilization of fifth metacarpal neck fractures: a prospective randomized study. The Journal of Hand Surgery. 2008;33(8):1362-1368).* When off all analgesics (usually 3-10 days) he is allowed to remove the splint and shower providing 1) he is just moving it but not using it stressfully, and 2) it does not hurt him to move it. The pain guides the movement. Reassess the patient at 7 days to be sure there is still no unacceptable rotation (scissoring) or angulation. Wear the splint during possible stress activities of daily living and during sleep. Splint is no longer required when it no longer hurts to use the hand, which is usually 2-4 weeks, post injury or reduction. Keep PIP and DIP joints moving from the beginning guided by pain to keep tendons gliding.

· **Subluxated intraarticular 2<sup>nd</sup> through 5<sup>th</sup> metacarpal fractures of the CMC or MP are all individual and will require surgeon guidance.**

· **When the fracture is solidly healed**, usually at 6-10 weeks, forceful very frequent active

movement (several times per hour with sustained holding and the patient counting to 10) to get the last few degrees of ROM can be initiated. At this point, pain is allowed as it is no longer the pain of fracture fragments moving, but it is the pain of stretching shortened ligaments. If frequent forceful active movement is not gaining after 4 weeks, passive forces can be applied.

If you would like a digital version of this protocol, contact Amanda Higgins at [grashay@nb.sympatico.ca](mailto:grashay@nb.sympatico.ca)

### References

- <sup>1</sup> Feehan, L. Early controlled mobilization of potentially unstable extra-articular hand fracture. *Journal of Hand Therapy* Volume 16, Issue 2, Pages 161-170.
- <sup>2</sup> Thien TB, Becker JH, Theis JC. Rehabilitation after surgery for flexor tendon injuries in the hand. *Cochrane Database Syst Rev.* 2004 Oct 18;(4)
- <sup>3</sup> Higgins, A, Lalonde, DH, Bell, M, McKee, D, Lalonde, J. Avoiding flexor tendon repair rupture with intraoperative total active movement examination. *Plast Reconstr Surg* 2010. 126(3):941-945
- <sup>4</sup> Tang JB. Indications, methods, postoperative motion and outcome evaluation of primary flexor tendon repairs in Zone 2. *J Hand Surg (European Volume)* 2007; 32E : 2 :118-129.

## Calendar

### 2015

#### January 21-24, 2015

AAHS Annual Meeting  
Atlantis Resort  
Paradise Island, Bahamas

#### February 9, 2015

AAHS Webinar Series:  
Flexor Tendon Injuries –  
Management of Acute  
and Delayed Injuries

#### March 19-21, 2015

Brazilian Society of Hand  
Surgery's 2015 Annual  
Meeting  
Iguassu Falls, Brazil

#### June 17-20, 2015

XX FESSH Congress  
Milan, Italy

### 2016

#### January 13-16, 2016

AAHS Annual Meeting  
Westin Kierland Hotel  
Scottsdale, Arizona

#### September 22-24, 2016

AAHS/DGH Joint Congress  
Frankfurt, Germany

## AAOS Volunteer Opportunities

Visit the AAOS Committee Appointment Program (CAP) webpage to review volunteer opportunities with upcoming deadlines. AAOS member login is required for application.

For specific questions, please contact [Donna Malert](#), AAOS Governance Manager.

[Learn More & Apply](#)

## CODING CORNER: Compressive Neuropathies

Hand and upper extremity surgeons frequently care for patients with compressive neuropathies. This edition of the Coding Corner will focus on appropriate coding for the treatment of carpal tunnel syndrome, cubital tunnel syndrome, and radial nerve compression.

Carpal tunnel syndrome is the most common compressive neuropathy affecting the upper extremity. Having failed conservative treatment options like splint immobilization and corticosteroid injections, patients may opt for surgical intervention. CPT 64721 describes neuroplasty of the median nerve at the carpal tunnel and includes services such as infiltration of local anesthesia, closure of the wound, and division of the transverse carpal ligament. Interestingly, CPT 25075 (excision, tumor, subcutaneous) is not separately reportable and cannot be used to describe the work of excising a lipoma if one is encountered within the carpal tunnel! In these situations, only CPT 64721 can be reported.

CPT 29848 is used to describe the work involved with an endoscopic approach for carpal tunnel release. CPT 29848 generates 6.39 work relative value units (RVUs) for the operating surgeon, while CPT 64721 generates only 4.97 work RVUs.

Coding for revision carpal tunnel procedures can be ambiguous. The operating surgeon may prefer to use a rotational fat flap

to prevent adhesion formation. Unfortunately, no specific code exists to describe fat pad coverage. Modifier -22 should be appended to CPT 64721 to describe the additional work required to complete the revision surgery. It is wholly inappropriate to attempt billing for flap or graft procedures. If a flexor tenosynovectomy is performed, modifier -22 should again be appended to CPT 64721. Wrapping the median nerve with a collagen conduit during revision surgeries may help to prevent adhesion formation and secondary nerve impingement. However, this can only be billed as CPT 64999 (unlisted procedure, nervous system) since the conduit is not being used to facilitate a nerve repair per se. Avoid using CPT 64910 (nerve repair with synthetic conduit) in these situations.

*Carpal tunnel syndrome is the most common compressive neuropathy affecting the upper extremity. Having failed conservative treatment options like splint immobilization and corticosteroid injections, patients may opt for surgical intervention.*



**Eon K. Shin, MD**

There exist several different options in treating cubital tunnel syndrome. CPT 64718 is appropriate when performing an in situ release of the cubital tunnel, a subcutaneous transposition of the ulnar nerve, or a medial epicondylectomy. When a submuscular transposition of the ulnar nerve is performed, use CPT 24305 (tendon lengthening, upper arm or elbow) with modifier -59. CPT 64718 will net the operating surgeon 7.26 work RVUs, and including CPT 24305 can add an additional 7.62 work RVUs.

As there is no CPT code (yet) to describe the work of performing an endoscopic cubital tunnel release, it is appropriate and reasonable to use CPT 64999 (unlisted procedure, nervous system) for now.

Finally, release of the radial tunnel is unspecified by its own CPT code. CPT 64708 (neuroplasty, major peripheral nerve) should be used to describe the work of releasing the radial nerve in the proximal forearm.

## AMA RESIDENT REPRESENTATIVE: Eric R. Wagner, MD

It has been my privilege to serve as the delegate representing the AAHS at the American Medical Association's (AMA) interim meeting in Dallas, Texas. I have had the privilege to serve on the AMA's research committee during this meeting, organizing the research symposium that took place the first two days of the meeting. Furthermore, I worked on multiple health policy groups and participated in a variety of meetings targeting the many changes currently taking place in the current healthcare climate. These experiences have enabled me to develop a foundation across the AMA to serve as the advocate and voice for the AAHS and hand surgeons amongst the young leaders in medicine.

The AMA meeting is one of the few places in medicine where leaders from all aspects of medicine join together with a common goal of improving healthcare for the patients and providers. As the most powerful medical organization in Washington, with influences throughout the world, this organization represents the foundation for

shaping the future of medicine. As an aspiring hand surgeon, it represents the ideal opportunity to establish a foundation in health policy and eventually to gain influence to introduce changes that will improve our colleagues' pursuits and vocation.

The focus of this meeting dealt with the many issues in healthcare reform, including the investigation into bundled payment systems, sustainable growth rate, insurance reform, and the influence of malpractice caps. Furthermore, there is a strong push to attempt to rain in student debt and reform the structure of student loans. With the changing landscape in Washington, the AMA figures to play a key role in helping to decide how our field of medicine is shaped in the upcoming years. Particularly valuable to hand surgeons, there continues to be a large push to research alternatives to transferring the financial risks from the patient and insurance company, to the provider, as is potentially the case in many of the more recent reforms.

By enabling a resident to represent AAHS at the AMA, it hopefully will be extremely valuable to its members and leadership. By starting early in their career, it enables them to entrench themselves within the organization, and allow their voice to grow. As the resident pursues the multiple leadership opportunities within this organization, their voice and influence representing hand surgeons will continue to grow. As the representative, I will continue to pursue these opportunities, navigating through the ranks of the AMA guided by mentors such as Dr. Peter Amadio and Dr. David Lichtman (the ASSH faculty delegate). Following in the path they have carved throughout their careers will help me to build upon all that they have accomplished. This is the ideal time to become involved in health policy, with the changing healthcare climate in Washington. Hand surgeons deserve a voice to be heard and a seat at the table. Through your sponsorship, I will work to be this voice.

Thank you for the opportunity,  
-Eric R. Wagner

*As the most powerful medical organization in Washington, with influences throughout the world, this organization [AMA] represents the foundation for shaping the future of medicine. As an aspiring hand surgeon, it represents the ideal opportunity to establish a foundation in health policy and eventually to gain influence to introduce changes that will improve our colleagues' pursuits and vocation.*

## LEADERSHIP PROFILE: Warren C. Hammert, DDS, MD

Dr. Warren Hammert is currently serving as Senior Director at Large. He became a member of AAHS in 2007.

Warren had an unusual path to becoming a hand surgeon. He grew up in Oklahoma, attending college and dental school there. Upon completion of dental school, he began an Oral and Maxillofacial Surgery residency at Allegheny General Hospital in Pittsburgh, PA and completed Medical School at the Medical College of Pennsylvania.

His initial intention was to become a craniofacial surgeon, so he entered a Plastic Surgery residency program at the Cleveland Clinic. During this residency, he developed his interest in hand surgery and completed an Orthopaedic Hand Fellowship at the University at Buffalo in Buffalo, NY. He began practice at the Cleveland Clinic and moved to Rochester, NY in 2006, where he is currently Professor of Orthopaedic and Plastic Surgery, Chief of the Division of Hand Surgery in the Department of Orthopaedics and Rehabilitation.

His practice consists of all aspects of hand, wrist and forearm surgery, including congenital, peripheral nerve, and reconstructive microsurgery. Warren has an interest in teaching and is involved with education of hand surgery fellows, orthopaedic and plastic surgery residents, and medical students and was recognized with resident teaching awards in the Department of Plastic Surgery in Cleveland and the Department of

Orthopaedic Surgery in Rochester. His research interests include clinical outcomes and evidence based medicine. He has authored several peer-reviewed articles and book chapters on various topics in hand surgery.

His service to AAHS includes the annual meeting program committees and has served as the chair of the Comprehensive Hand Review course at the annual meeting in Naples in 2013. He is also currently on the research committee and the finance committee.

He serves as a consultant reviewer for Hand. He has worked with Josh Abzug, another board member, to develop the newly formed webinar series as part of the AAHS outreach mission.

Outside of medicine, Warren enjoys spending time with his wife and children. He closely follows his alma mater, Oklahoma State University sports teams. The summer months involve cycling (road bicycle) and in the winter, he enjoys snow skiing.

He always looks forward to the AAHS annual meeting, as the warm weather is a needed break from the Rochester winters.



### VARGAS AWARD DEADLINE: JANUARY 9, 2015

The Vargas Award's intent is therapy outreach and to foster an exchange of educational ideas between therapists in the AAHS and in host countries to result in improved patient care for upper extremity problems.

One grant reimbursing up to \$5,000 in trip-related expenses, including supplies needed for the mission, will be awarded to the therapist recipient.

#### Who can apply for the Vargas Award?

The Vargas Award will be granted to a hand therapist currently practicing in the area of hand therapy. A practicing hand surgeon may apply to accompany a therapist on a mission; however, no funding will be awarded to the surgeon. Surgeons chosen for a Vargas mission are expected to be self-funded or seek outside funding.

FOR ADDITIONAL DETAILS AND TO APPLY, <http://handsurgery.org/endowment/vargas.cgi>

## LEADERSHIP PROFILE: Joy MacDermid, BScPT, MSc, PhD

Joy has been a member of AAHS since the early 2000s, serving as an AAHS Board Member and past Program Committee Member, Scientific and Clinical Papers Chair, and Scientific Meeting Co-Chair. She is also the past president of the American Society of Hand Therapists (ASHT), has twice won ASHT's Best Scientific Paper Award, was awarded the Nathalie Barr Lecture in 2006 and the Philadelphia Hand Meeting Honored Professorship in 2006 and 2012.

Joy grew up in Cape Breton and graduated with a Bachelor of Science from St. Mary's University in Halifax, Nova Scotia. She put her biology degree to use working with mice in a basic science lab for 2 years. Joy later moved to London, Ontario to train as a physical therapist at the University of Western Ontario and has since acquired more than 25 years of clinical experience in hand therapy.

After years of working as a clinician, Joy returned to academia to pursue a Master's degree in Physical Therapy and a Doctorate in Epidemiology and Biostatistics at the University of Western Ontario. She is Professor in Rehabilitation Science at McMaster University, Hamilton, Ontario and is the Co-director of Clinical Research at the Hand and Upper Limb Centre, London, Ontario. Joy is heavily engaged in training students and teaching courses in upper extremity musculoskeletal clinical skills, evidence-based practice, work disability, quality of life and knowledge exchange

and transfer. She also holds a CIHR Chair in Gender, Work and Health and is a Fellow of the Canadian Academy of Health Sciences.

Joy has published more than 300 peer-reviewed papers, including systematic reviews, development/evaluation of outcomes measures, clinical trials, knowledge transfer, clinical practice guidelines and identification of clinical predictors. Her research and clinical interests focus on musculoskeletal pain and disability resulting from upper extremity disorders and the impact of these disorders on work and subsequent health and quality of life. Joy has developed and evaluated measures that assess pain, function or work outcomes, as well as advanced new methods in content validation. Her wrist scale, The Patient-Rated Wrist Evaluation, has been translated into more than 15 languages and is used internationally in clinics and research studies.

A Cape Bretoner at heart, Joy tries to go back to Cape Breton as much as possible in between her research and teaching activities. She has 5 children and 3 grandchildren and enjoys watching them play hockey.



### Download the AAHS *HAND* Journal on your Android Device



The *HAND* Journal Committee is pleased to announce the availability of the *HAND* journal Android mobile app! The app is available for download for Android devices in [Google Play](#) and provides instant access to all current and past issues of the journal dating back to its inception in 2006. Once the app has downloaded to your device, you will need to login with your personal AAHS username and password once for authentication. Then you can use the app functions to browse volumes and full text articles, search for work by specific authors, and more.

Please contact the administrative office at [contact@handsurgery.org](mailto:contact@handsurgery.org) if you have forgotten your AAHS username and password.

The Hand Journal mobile app is also available for download on Apple devices in the App Store by searching for "HAND Journal" or "AAHS Journal."



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*Coastal Orthopaedics  
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### Association Advocacy 2014

- Supported the travel of Drs. Peter Amadio and Nicholas Vedder who attended two AMA meetings as AAHS Representatives and participated in caucus sessions.
- Sponsored Dr. John Fowler's attendance at the 2014 AAOS Research Capitol Hill days.
- Worked with the AAOS on a taskforce for provision of comment on sex-specificity in FDA device clinical trials.
- Signed onto a letter which was submitted to the NIH Committee on Research on Women's Health to support expanding NIH research efforts examining sex and gender similarities and differences in musculoskeletal science.
- Signed onto a letter which was sent to orthopedic industry and urged greater support for orthopedic GME.
- Signed onto a letter which was sent to the FDA in response to the draft guidance on the Custom Device Exemption.
- Signed onto an AMA letter requesting that CMS delay the implementation of its revised hospital Conditions of Participation regulations.
- Signed onto an AAOS letter regarding the SGR payment system repeal and passage of a new payment system which emphasizes quality of patient care.
- Dr. Eric Wagner attended two AMA meetings as an AAHS Representative.

# AAHS Job Board

## Hand and Upper Extremity / 2015 / Charleston, SC

Charleston Hand Group is recruiting a BE/BC orthopedic surgeon with fellowship training in hand surgery. Due to demand and continued growth, this well established successful hand group has an excellent opportunity for a hand surgeon. Candidates should be proficient in a broad range of hand and upper extremity conditions including trauma care and microvascular surgery. The candidate will join a hand group that is part of a twenty-four surgeon orthopedic service line of all specialties, three state-of-the-art hospitals, and a free standing ambulatory surgery center. Convenient Occupational Therapy, in-house fluoroscopy, and ultrasound on site. Shared call limited to hand only. Excellent employment opportunity with competitive salary and benefits. Charleston Hand Group is part of Roper Saint Francis Physician Partners (RSFPP). RSFPP is a comprehensive network of more than 215 physicians that covers a complete range of primary care and 20 subspecialties. Roper St. Francis Physician Partners has physician practices in seven counties throughout South Carolina providing our community convenient, comprehensive and compassionate healthcare. Roper St. Francis cares for more Lowcountry families than any other healthcare provider in our area. Our mission is simple: Healing all people with compassion, faith and excellence. [www.rsfh.com](http://www.rsfh.com)  
Contact: Julie Radabaugh, Physician Recruiter, Roper St. Francis Healthcare, [julie.radabaugh@rsfh.com](mailto:julie.radabaugh@rsfh.com) / (843)789-1540 / [www.rsfh.com](http://www.rsfh.com) - go to physician careers.

## Orthopaedic Hand Surgeon / Immediate / Paducah, KY

The Orthopaedic Institute of Western Kentucky is the area's premier specialty center for all Orthopaedic treatment. The Orthopaedic Institute provides care for every subspecialty area of orthopaedics including total joint reconstruction, shoulder & knee, hand & wrist, sports medicine/arthroscopy, back & neck, foot & ankle

and general orthopaedics. At The Orthopaedic Institute, the physician support and ancillary staff are dedicated professionals who work together to provide patients with exceptional care and return them normal activities as soon as medically possible.

Along with our specialty clinics, we also have the most advanced diagnostic equipment as well as the regions premier rehabilitation specialists. The fact that we provide only orthopaedic services has allowed our rehabilitation team to become experts in the field. The level of care and service provided at The Orthopaedic Institute is unsurpassed in this region as proven by our patients consistently providing us with the highest marks in patient satisfaction and overall medical experience.

We are currently looking for an exceptional Orthopaedic Hand Surgeon to join us.

Job responsibilities: Out-patient exam, evaluation, treatment and follow-up, Surgery, Patient/Family education, Hospital Call Rotation.

Benefits include: Excellent Salary and bonus structure, Health, Life, Dental and LTD insurance, Office and clinic in a new, award winning facility, and Partnership Opportunities.

Candidate Requirements: BC/BE orthopaedic surgeon, fellowship trained in hand surgery; Must be licensed in the State of Kentucky; 2 years experience preferred; Specialty in Orthopedics-hand surgery; Ability to work well with a team of other doctors.

Contact: Chad Walker, PHR, Director of Human Resources, The Orthopaedic Institute of Western Kentucky, (270) 450-7101 / [cwalker@sioc.com](mailto:cwalker@sioc.com)

## Hand Surgeon / Immediate / Phoenix, Arizona

An immediate opportunity exists in the Department of Surgery of District Medical Group (DMG) for a full-time hand surgeon with a strong interest in academics and trauma. The Department staffs Maricopa Medical Center, a community hospital with a State and American College of Surgeons designated Level 1 Trauma and Burn Center in the metropolitan Phoenix area. The Department is seeking a hand surgeon

interested in resident education to join and become an integral member of a busy hand practice. The practice has a strong emphasis on trauma, and is supported by the general surgery trauma team. The surgeon would be appointed to the Department of Surgery with responsibilities relating to serving as a faculty member and assisting the Hand Section Chief in developing the clinical service line, traditional inpatient and outpatient services in the elective, urgent, and emergent care of the hand patient, teaching, and on-call coverage. The Department also hosts a General Surgery and Surgical Podiatry Residency Program, and provides supervision to resident rotators in plastic surgery.

The preferred candidate must be board certified and/or eligible, and have completed the Certificate in Added Qualifications for Hand, or Surgery Of The Hand certified/eligible, and should be comfortable with a teamwork approach for patient management.

DMG is a large multi-specialty physician group practice (approximately 350+ physicians) offering a great teaching and work environment, competitive salary, and comprehensive benefits package.

Contact: Interested applicants please provide a cover letter and CV by email to [practice@dmgaz.org](mailto:practice@dmgaz.org)

## Hand Surgeon / Immediate / Dakota Dunes, SD

Excellent opportunity to join an independent multispecialty group of 25 physicians with 2nd call for hand only. Partnership and investment opportunities after one year. Clinic owned Occupational Therapy, Physical Therapy, MR and DME, along with ownership in a licensed surgical hospital. Competitive Salary and Benefits package in a state with NO state income tax. Contact: Nancy Swanson / 605.217.2674 / [nancy.swanson@CNOS.net](mailto:nancy.swanson@CNOS.net)

Hand  
Surgery  
Quarterly  
•••  
Winter  
2015

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(continue on next page)



# AAHS Job Board (continued)

## Hand Surgeon / Immediate / Phoenix, AZ

Heal the sick, advance the science, share the knowledge. The Plastic, Reconstructive and Hand Surgery Division at Mayo Clinic in Arizona is seeking a fellowship trained, CAQHS certified/eligible hand surgeon interested in an academic career. The ideal candidate will possess a clinical interest in brachial plexus and peripheral nerve paired with exceptional clinical skills. We are looking for a candidate who is committed to teamwork, excellence and innovation.

The successful candidate will join the Division in the Section of Hand Surgery that currently includes two busy hand surgeons at a Level II trauma center. The candidate will serve an active role in the education of medical students and integrated plastic surgery residents.

Mayo Clinic has been recognized as the best hospital in the nation for 2014-2015 by U.S. News and World Report. We are an integrated, multidisciplinary academic medical center with comprehensive programs in medical education and research that span across three group practice sites. We support a vibrant research enterprise, with programs in clinical, basic and population sciences. In 2013, the institution received nearly \$370 million in extramural research awards, supplemented with over \$275 million of institutional support. We offer a highly competitive compensation package with sustained intramural funding, capital equipment funding, technical and computational resources, and exceptional benefits.

To apply online and learn more about Mayo Clinic and the vast array of opportunities that await you, please copy and paste this URL into your browser: <http://mayocl.in/12n9WJF>

Inquiries may be sent to: Raman Mahabir, M.D., Chair, Division of Plastic, Reconstructive, and Hand Surgery, c/o: Katherine Harris, Physician Recruiter, Mayo Clinic in Arizona, [Harris.Katherine@Mayo.edu](mailto:Harris.Katherine@Mayo.edu)

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## Orthopaedic Hand Surgeon / July 1, 2015 / University of Kentucky, College of Medicine, Dept. of Orthopaedic Surgery

The Department of Orthopaedic Surgery at The University of Kentucky is seeking a Fellowship trained orthopaedic hand surgeon to join our growing practice. This position will carry a full-time faculty appointment at The University of Kentucky and salary will be commensurate with experience.

Basic Qualifications: Applicants must be American Board of Orthopaedic Surgery Board-certified/eligible; fellowship trained in hand surgery by an accredited program prior to appointment to the position, and eligible for licensure in the Commonwealth of Kentucky.

Upon offer of employment, successful applicants must pass a pre-employment drug screen and undergo a national background check as required by the University of Kentucky Human Resource Department.

The University is an Equal Employment Opportunity/Affirmative Action employer that does not unlawfully discriminate in any of its programs or activities on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, gender identity or expression, or on any other basis prohibited by applicable law.

Contact: Please send C.V. along with 3 letters of reference (one from the Fellowship Director) to: Darren L. Johnson, M.D., Chair & Professor, Department of Orthopaedic Surgery, Kentucky Clinic, Attn: Pauline Mills, 740 South Limestone, Suite K401, Lexington, Ky. 40536-0284 / Tel: 859-218-3055 / Fax: 859-323-2412 / [pmills@uky.edu](mailto:pmills@uky.edu)

## Orthopedic Hand Surgeon / ASAP / Sacramento, CA

ACHIEVE extraordinary outcomes when you're part of Mercy Medical Group, a multi-specialty group with more than 375 healthcare providers in the Sacramento region and a service of Dignity Health Medical Foundation, you'll be able to do more than just care for your patients. You'll have the opportunity to develop and participate in health, education and wellness programs that will help improve the lives of people throughout your community...and beyond. If you want to achieve extraordinary outcomes, join us today.

We are currently seeking a fellowship-trained provider for our busy Orthopedic Surgery Department. Our doctors provide services to patients at Dignity Health Medical Foundation's Mercy Medical Group locations throughout Sacramento. The successful candidate must be fellowship-trained in Hand Surgery and be BC/BE in Orthopedics. Surgeries will be performed at Mercy General Hospital ([www.mercygeneral.org](http://www.mercygeneral.org)). Call of 1:5 is required, with Hospitalists available 24/7.

Our Medical Foundation is aligned with one of the largest health systems in the nation and the largest hospital system in California. All of our outpatient medical offices are equipped with a full electronic medical records system and our physicians benefit from excellent primary care and consultation support and a collegial, supportive environment. This shareholder-track opportunity offers a very competitive compensation and benefits package, including bonus potential and a very desirable retirement plan.

Sacramento is one of the fastest growing cities in the nation and one of the most affordable places to live in California. The area offers a wide variety of activities to enjoy, including fine dining, shopping, biking, boating, river rafting, skiing and cultural events. Lake Tahoe, the Pacific coastline, San Francisco, the vineyards of Napa and Sonoma Valleys and the historic Gold Rush towns of the Sierra foothills are all within easy driving distance.

Contact: Colin Harris, Sr. Physician Recruiter, Phone: 888-599-7787 / [providers@dignityhealth.org](mailto:providers@dignityhealth.org) / [www.mymercymedgroup.org](http://www.mymercymedgroup.org) / [www.dignityhealth.org/physician-careers](http://www.dignityhealth.org/physician-careers)

To include your job posting on the AAHS website and in the next issue of Hand Surgery Quarterly, please visit <http://handsurgery.org/job-board.cgi>.

**AAHS WEBINAR SERIES  
FLEXOR TENDON INJURIES:  
MANAGEMENT OF ACUTE AND DELAYED INJURIES  
FEBRUARY 9, 2015 | 8:00 – 9:30 PM EST**



**Webinar Overview:**

Introduction and Overview

**James Chang, MD, Moderator**

Zone I and Proximal Flexor Tendon Injuries

**Warren C. Hammert, MD**

Principles of Management and Treatment of  
Zone II Injuries (Acute and Chronic)

**Steve K. Lee, MD**

Managing Flexor Tendon Repair and It's  
Complications with Wide Awake Surgery

**Donald H. Lalonde, MD**

Rehabilitation Following  
Flexor Tendon Injuries

**Rebecca von der Heyde, OTR/L, CHT**

Q&A, Discussion and Case Presentations

**James Chang, MD, Moderator**

**Register at <http://www.prolibraries.com/aahs/>**

*To fulfill its mission devoted to advance global hand care and education, the AAHS has developed a new webinar series focused on providing hand care to the global community with the goal to provide education internationally to improve hand care. The AAHS Webinar Series is a **free** educational program for medical professionals around the globe focused in upper extremity care. Content is geared towards an international audience.*

**Past Topics are archived on the AAHS website:**

**<http://handsurgery.org/education/webinar.cgi>**

**Hand Trauma: Management of Acute and Delayed Injuries (August 5, 2014)**

**Pediatric Hand and Wrist Trauma (November 4, 2014)**