I would like to encourage you to attend the 28th Annual Meeting of the American Association for Hand Surgery in Scottsdale, Arizona. The theme for this year's meeting is Hand Surgery for the 21st Century.

Accordingly, there will be free papers and panels dealing with contemporary issues and topics faced by hand surgeons today as well as in the upcoming 21st Century.

The program this year will include 66 free papers on subjects ranging from arthritis to congenital problems. Fifteen of these 66 papers have been selected by the Resident Essay Committee, chaired by Brian D. Adams, MD. These will be intermixed with the other papers on Thursday and Friday and will be eligible for awards. Scientific posters selected by the Poster Committee chaired by Burt M. Greenberg, MD will be available for viewing on Thursday and Friday. And for the second year in a row, a videotape library will also be available.

John Texter, MD, Dr. Robert Russell's Presidential Invited Lecturer, will present a fascinating lecture entitled "Diseases of the Presidents." I have invited Mark Harmon from Chicago Hope to be our Keynote Speaker. He will discuss his interaction with my office during the making of the episode dealing with the cross hand transfer. In addition, he will show a video of some humorous out-takes from Chicago Hope.

A socioeconomic panel moderated by Elvin G. Zook, MD will discuss man power issues that face hand, plastic, and orthopedic specialties.
FROM THE EDITOR'S DESK

Professional Responsibility and Personal Integrity

As preparations begin for the 28th Annual Scientific Meeting of the American Association for Hand Surgery, I am reminded of an editorial that I vowed to write immediately after the Boca Raton meeting. The issue of professional responsibility rankled me as I watched your already badly harassed Scientific Program Chairman cope with the ‘no-shows’ on the Scientific Program. I believe the total number of papers not given was 8 (eight)!

Some will argue that it is a ‘product of our time’ or ‘of the nineties’. Bunk. Pure bunk! When you submit an abstract for a national presentation, your Scientific Program Chair assures that this will be a product of your best work and that your scientific conclusion has been proven and the data has been collected and analyzed (note the use of the past tense).

Submission of a scientific abstract is NOT the same as buying an airline ticket. Your professional and scientific credentials are not on the line when you approach the airline ticket counter to purchase a ticket. If we begin to accept any excuse(s) for a ‘no-show’ at a national scientific meeting, we should begin to ‘overbook’ the scientific program. In my opinion, such an attitude would nicely enhance the decline of American medicine in deference to the ‘bottom line’ mentality of managed health care organizations which think that any problem can be solved by throwing money at it.

The scientific program of any organization is the backbone of advancement of knowledge about the clinical management of most diseases and traumas. Presentation of your work in front of your ‘peers’ is a fundamental basis of the scientific method. One has only to look at the science as it is presented in a court of law to understand the strength of any argument that is based on ‘peer review’. Thus, acceptance of your work by your ‘peers’ validates your conclusions.

Any ‘activity’ which diminishes the interplay of peers and the speaker at the scientific meeting erodes the entire process. These ‘activities’ range from falsifying data; inappropriate citations and professionalizing personal biases to failing to show up to present your paper. Any of these activities and others publicly demonstrate your professional irresponsibility.

Therefore, I want to remind us all that ‘no-shows’ for scientific programs are socially unacceptable. See you all soon.
R&R Ops Abound in Scottsdale

Plans for this year’s Annual Meeting of the American Association for Hand Surgery in Scottsdale, Arizona are now complete. Rick Brown, MD and his Program Committee have organized an outstanding scientific program which includes 3 panels, 74 scientific papers, and 22 instructional courses. The general interest topics of the three invited speakers should be of interest to the members as well as their spouses.

The Annual Meeting also provides a number of social activities which are available to your entire family. As always, we will be hosting our annual golf tournament which will be held on Saturday, January 10, during the AAHS/ASRM joint day with members from both organizations participating in this scramble. This year we have also added a few extras to make the golf tournament more interesting. There will be a number of give-away prizes which we have not previously offered. On four different holes there will be an opportunity for players to win a Lincoln Mercury Mountaineer, one of two Caribbean cruises, or a new set of golf clubs (if you can hit a hole-in-one!). There will also be cash prizes for the lowest net score of a foursome, lowest gross score of a foursome, closest to the pin, and longest putt. The cost of this outing is $150.00 per player, which includes a box lunch, green fees, and a golf cart. Even if you are not lucky enough to win an official prize, everyone who signs up will receive a sleeve of golf balls and a commemorative photo.

In addition to the golf tournament, we will also sponsor an Annual Tennis Tournament, also on Saturday, January 10. Both AAHS and ASRM members will be participating and there will be cash prizes for the two top male and female winners. This event is organized as a round robin tournament and the fee will be $90.00. All participants will receive beverages, towels, tennis balls, and a one hour tennis clinic prior to the tournament. Please check the registration form in the registration brochure and sign up for golf or tennis, but try to make your reservation before December 8, 1997!

For those of you who enjoy less strenuous forms of relaxation, on Saturday afternoon there will be an Accessory Fashion Show hosted by Saks Fifth Avenue, which will highlight the season’s hats, scarves, belts, jewelry, handbags, and shoes. This has been a very popular event for spouses in previous years.

Mr. Robert J. Rosepink, a partner of Rosepink and Estates, a Scottsdale, Arizona law firm specializing in real estate planning, probate and trust law will also be joining us. He will give a presentation on Friday, January 9, on the topic of planned giving which will include charitable trusts, charitable trust annuities, and outright gifts of appreciated property. These options can be used to avoid taxes and hopefully become a contributor to The Hand Surgery Endowment, which supports the educational programs of the American Association for Hand Surgery. In addition, American Express Financial Services will be holding workshops which you can attend in addition to the main scientific program. The two 35-40 minute workshops, ‘The New Deferred Compensation Plan’ and ‘Estate Planning and Tax Reduction’ will be held throughout the Annual Meeting. These two educational

continued on page 5
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FROM THE PRESIDENT
continued from page 3

workshops, pertaining specifically to surgeons, will provide information on timely financial topics.

The opening Welcome Reception will be held on Thursday, January 8 at the Phoenician Resort and the Annual Awards Dinner Dance will be held on Friday, January 9. This year we are taking a new approach on the usual formal black tie event to take advantage of the Southwestern setting in Scottsdale. This year’s awards dinner dance, titled ‘Oaxacan Nights’, will be more casual and will highlight the culture of the Oaxacan Indians of Mexico. A salsa band and authentic southwestern Mexican-American food will make this a very special night.

Our final social event will be a reception Saturday night with ASRM, entitled ‘An Evening at the Jokake’, which will also give a chance to enjoy the pleasant outdoors of Arizona. As Jokake is a rustic restaurant on the resort’s property, you won’t have to go far to take advantage of the Southwest atmosphere.

Finally, don’t forget to take full advantage of the wonderful facilities that will be present at the Phoenician Resort. The resort has a number of pools, including one with a 165 foot water slide for kids of any age. The health spa invites you to enjoy its body and beauty treatments, sauna, steam baths, and massage tables. The resort also has 11 tennis courts, 27 holes of golf, and a day program for children at the kid camp. More information on the spas, kids camp, and other optional tours can be obtained from the resort at 602/941-8200.

All in all, this year’s meeting will not only meet your educational needs, but is a wonderful setting to enjoy time with your entire family. I look forward to seeing all of you in Scottsdale.

MESSAGE FROM THE PROGRAM CHAIR
continued from page 1

dic surgeons, as well as hand therapists today. This panel will raise issues about resident and therapist training and the potential need for cutting back on training. Dr. Robert L. Walton will moderate a panel on Friday entitled, “A Day in the Office”. He will present his panel with challenging cases. An AAHS/ASRM joint panel on replantation will be held on Saturday and moderated by ASRM member Gregory M. Buncke, MD.

The panel will focus on the socio-economic impact as well as the functional impact of replantation.

I would like to thank all the members of the Program Committee for their help on this year’s program as well as to Shirley Cohen, OTR/L, CHT for organizing the Pre-Conference Seminar and integrating therapists into our panels. I would also like to thank the Central Office, especially Ms. Cathy Hay and Laura M. Downes, CAE, who have been instrumental in putting this year’s program together.

Richard E. Brown, MD
Chair, 1998 Scientific Program Committee

 Proposed Bylaws Changes

Listed below are the proposed changes to the Bylaws as approved by the Board of Directors. These changes will be presented to the general membership for approval at the Annual Business Meeting.

ARTICLE III - MEMBERSHIP
Section 4 - Active Membership
A. Active membership shall be limited to those surgeons who are certified by the American Board of Orthopedic Surgery, Plastic Surgery or Surgery, or their Canadian equivalents, or by the American Board of Osteopathic Orthopedic Surgery or Surgery and who have the following qualifications:

ARTICLE V - BOARD OF DIRECTORS
Section 8 - Election Rotation
The Historian and two Directors-at-Large shall be elected every year. Of the two directors, one shall be an active member for not more than (7) seven years and the other, more than seven years. The Secretary, the Membership Committee Chair, and the Finance Committee Chair will be elected in the same year. The Treasurer and the Ethics Committee Chair will be elected in the same year. The Time and Place Committee Chair and the Education Committee Chair will be elected in the same year.

ARTICLE VIII - COMMITTEES
Section 2 - Special Committees and Ad Hoc Committees
Special Committees and Ad Hoc Committees may be appointed and charged by the President with the approval of the Board of Directors, which will determine their powers, responsibilities, and terms of office.

ARTICLE X - FISCAL POLICIES
Section 3 - Entrance Fees Initiation Fees

Underline: add or amend  Strike over: delete
American Association for Hand Surgery
1998 Slate of Candidates

Officers
President (automatic)  Peter C. Amadio, MD
President-Elect (automatic) William M. Swartz, MD
Vice President William F. Blair, MD
Historian Miguel J. Saldana, MD
Directors-At-Large Randy Sherman, MD
Allen L. Van Beek, MD

Committee Chairmen
Finance Committee Ronald E. Palmer, MD
Membership N. Bradley Meland, MD
Nominating Committee Lee E. Edstrom, MD
James G. Hoehn, MD

Applicants for AAHS Membership

Candidates for Active Membership
Adler, Hilton C. East Setauket, NY
Aron, Michael Hartford, CT
Cohen, Mark S. Chicago, IL
Coleman, Woodward L. San Antonio, TX
Crimmins, Curtis A. Milwaukee, WI
Desai, Sanjay, S. Richmond, VA
Fattore, John E. Norwood, MA
Galli, Randi A. Fresno, CA
Hanlon, Jon J. La Habra, CA
Havlik, Robert J. Indianapolis, IN
Johnson, Craig H. Rochester, MN
Jones, Michael L. San Antonio, TX
Lindley, Shelia G. Jackson, MS
Lindsey, John T. Metairie, LA
Meyer, Richard D. Birmingham, AL
Murray, Peter M. Lackland AFB, TX
Raab, Michael G. Fort Gordon, GA
Rehak, David C. Columbus, GA
Riley, Scott A. Lexington, KY
Smith, Dell P. Provo, UT
Topper, Steven M USAF Academy
Trumble, Thomas E. Seattle, WA
Tracy, C. Alan Wheeling, WV

Candidates for Affiliate Membership
Bailey, Nancy A. Jackson, MS
Fletcher, Karyn J. Scottsdale, AZ
Ivy, Cindy Clare Scottsdale, AZ
Luckett, Karen Beverly Hills, CA
Paquette, Lorraine Phoenix, AZ
Schultz, Lisa A. Worcester, MA
Weisenborn, Stephanie A. St. Louis, MO

Membership Transfer from Affiliate to Active Membership
Bamberger, H. Brent Dayton, OH

Candidates for Corresponding Membership
Meuli-Simmen, Claudia Zurich, SW
# American Association for Hand Surgery
## 28th Annual Meeting
### January 7-10, 1998
#### The Phoenician Resort
##### Scottsdale, Arizona

## AAHS Program at a Glance

### Wednesday, January 7, 1998
- **7:30–8:30 am** Hand Therapy Seminar
- **Registration**
- **8:30 am–5:00 pm** Hand Therapy Seminar
- **12:00–5:00 pm** AAHS Annual Meeting Registration
- **12:00–5:00 pm** Poster Set up
- **1:30–5:00 pm** Board of Directors Meeting

### Thursday, January 8, 1998
- **7:00–7:30 am** Continental Breakfast
- **7:00 am–5:00 pm** Posters
- **7:30–7:45 am** Welcome
- **Richard E. Brown, MD**
- **7:45–7:55 am** Report from the 1997 Vargas Award Winner
- **Colette Jewell, OTR, CHT**
- **7:55–8:00 am** Clinician/Teacher of the Year Award
- **8:00–9:30 am** Scientific Paper Session 1
- **9:30–10:00 am** Break
- **10:00–10:10 am** IFSSH Annual Meeting Announcement
- **10:10–10:30 am** Presidential Address
- **Robert C. Russell, MD**
- **10:30–11:45 am** Scientific Paper Session 2
- **11:45 am–12:30 pm** Lunch
- **12:30–1:15 pm** Presidential Invited Lecturer
- **John Texter, MD**
- **1:15–2:15 pm** Manpower Panel
- **2:15–3:30 pm** Scientific Paper Session 3
- **3:30–3:45 pm** Break
- **3:45–4:15 pm** Presidential Invited Lecturer
- **Fritz Klein**
- **4:15–5:30 pm** Scientific Paper Session 4
- **6:30–8:00 pm** Welcome Reception

### Friday, January 9, 1998
- **6:30–7:00 am** Continental Breakfast
- **8:30 am–2:00 pm** Exhibit Hall Open
- **7:00–8:30 am** Instructional Courses (101–108)
- **8:30–9:15 am** Break
- **9:15–10:15 am** Scientific Paper Session 5
- **10:15–11:15 am** A Day in the Office Panel
- **11:15 am–12:00 pm** Keynote Speaker
- **Mark Harmon (Invited)**
- **12:00–12:45 pm** Lunch
- **12:45–1:45 pm** Scientific Paper Session 6
- **1:45–2:30 pm** Annual Business Meeting
- **2:45–3:30 pm** 1998 Board of Directors Meeting
- **6:30–7:00 pm** New Member Reception
- **7:00–11:00 pm** Awards Dinner Dance

### Saturday, January 10, 1998
- **6:30–7:00 am** Continental Breakfast
- **7:00–7:15 am** AAHS/ASRM Welcome
- **7:15–9:15 am** Joint Scientific Paper Session
- **8:30 am–12:30 pm** Exhibit Hall Open
- **9:15–10:00 am** Break
- **10:00–11:00 am** A New Look at Replantation Panel
- **11:00 am–12:00 pm** Instructional Courses (201–208)
- **12:00–2:00 pm** Poster Tear Down
- **12:30 pm** Golf & Tennis Tournaments
- **7:00–8:30 pm** Joint Reception–An Evening at Jokake Inn
**The Hand Surgery Endowment Reaches a Milestone**

Over $100,000 in Gifts and Pledges

The total of gifts and pledges to the Hand Surgery Endowment has now reached over $100,000. Twenty-five individuals have made a commitment to the support of the educational programs of AAHS. These donations, coupled with the Association Board of Director’s recent gift of $20,000, has resulted in the Endowment’s growth. While reaching over $100,000 is certainly a great achievement, we must not “rest on our laurels!” Much more is needed. How will we get there? By every member contributing as much as they can to the Endowment.

Your Opportunity to Give

Gifts are needed at every level—from the smallest amount to those over $20,000. Just pick the level you are comfortable with. You don’t need to give it all in one lump sum. That’s what pledges are for, so a sizable amount can be split into smaller, annual payments. As your gift(s) reach one of the designated levels of giving (see accompanying table), you will receive not only a letter of acknowledgment, but also one of the beautiful Endowment pins that have been prepared for you!

Another Way to Give!

When you receive your annual dues statement near the end of the year, you will be given the opportunity to add a suggested additional $150 designated for the Endowment. You will receive a receipt, itemizing the portion of your payment to the Endowment. Your contribution is tax deductible as the Endowment has officially been designated a 501(c)(3) corporation. Contributions made along with the dues payment is a convenient form of annual giving that will assure an important and consistent means of growth for the Endowment.

More Ideas to Benefit You and the Endowment

“Getting More Bang for Your Buck—Charitable Giving in Estate Planning” is the title of a presentation that will be given by Robert J. Rosepink, of Rosepink & Estes, at the AAHS 28th Annual Meeting in Scottsdale on Friday, January 9, 2:30–3:30 pm. All members are invited to glean ideas about charitable remainder trusts, charitable gift annuities, and outright gifts of appreciated property, to help in your estate planning. The seminar is free and no prior registration is required.

How is the Endowment Managed

There are five members of the Endowment’s Board of Governors, and they serve without compensation. Current board members are Robert R. Schenck, MD, Joseph Danyo, MD, Kim Lie, MD, Forst Brown, MD and Jay Menon, MD. Administrative and fund-raising costs are limited to 10% of total gifts received. Other endowments’ expenses range from 20 to 50%! The Hand Surgery Endowment’s remaining 90% of funds are invested for growth of the Endowment, and these funds can never be spent. The investment earnings support selected projects.

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**THE HAND SURGERY ENDOWMENT GIVING LEVELS**

Contribution dates as of October 2, 1997

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Members contributing to the Endowment at the established giving levels receive this beautiful, custom-designed pin.
Yes, I want to help the Endowment. Here is my tax deductible gift/pledge of:

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- I pledge a total of $________ to be paid $________ annually for ____ years.
- I want to make a bequest in my will of $________. Please send me more information.

Please make out checks to The Hand Surgery Endowment and mail with a copy of this form to:

The Hand Surgery Endowment
c/o Robert R. Schenck, MD
1725 W. Harrison St., Room 263
Chicago, IL 60612
Ph: (312) 738-3426
Fax: (312) 738-7298
E-mail: rschenckmd@aol.com

What is the Endowment Doing Now?

The Endowment will give two resident prizes totaling $600 at the Annual Meeting in Scottsdale. In addition, for the first time, the Endowment will give $100 awards for the best posters in each of two categories: Basic Science and Clinical Studies. These are just three examples of the kinds of activities which, with your help, can be carried out in the future.

Remember to Respond

Your contribution and that of every member is vital to our continued access to the latest and the best medical information that will help us in our practices. The future awaits but only for those who plan for it.

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PLEASE ADD $3 PER ITEM SHIPPING.
Athletic Injuries to the Thumb

This issue’s Around the Hand Table discusses athletic injuries of the thumb, starting out with some essentials, such as the Bennett’s fracture, extra-articular fractures of the base of the thumb, transverse and oblique fractures of the base of the thumb metacarpal, ulnar collateral ligament injuries and radial collateral ligament injuries. The panelists talk a little bit about diagnosis and, because these are sports injuries, focus on acute treatment, rehabilitation and protection for re-entry onto the playing field.

The moderator for the discussion is Alan E. Freeland, MD, Professor, Department of Orthopaedic Surgery, Director, Hand Surgery, University of Mississippi Medical Center. Joining him are panelists Terry R. Light, MD, Dr. William M. Scholl Professor and Chairman, Department of Orthopaedic Surgery, Loyola University of Chicago Stritch School of Medicine, Ronald E. Palmer, MD, Orthopaedic Institute of Illinois, Peoria, and Susan Michloitz, PhD, PT, Associate Professor, Department of Physical Therapy, Allegheny University of the Health Sciences and Hand Therapist, Department of Orthopaedic Surgery, Temple University, Philadelphia.

Dr. Freeland: I’d like to start off with the Bennett’s fracture, and ask Dr. Palmer how he would treat this fracture, and particularly, does fragment size play a role?

Dr. Palmer: The size of the fragment does play a role. Some physicians feel that a fragment involving over 40 percent of the articular surface is an indication for more firm fixation, for instance, screw fixation. Most all Bennett’s fractures are inherently unstable fractures because of the pull of the abductor pollicis longus at the base of the metacarpal. This tends to be the deforming force drawing the dorsal fragment proximally. I tend to pin these, usually with one pin, regardless of the size of the fragment, unless I can’t get an acceptable reduction of the metacarpal to the volar fragment. Then I would open it and use a screw or a K wire fixation. But if I felt that I could get the metacarpal back on the trapezium adequately and hold it with one or two pins, I prefer to do that percutaneously and then treat them in a thumb spica cast.

Dr. Freeland: Dr. Light, how about you? If you use pins, is there a particular configuration that you like?

Dr. Light: The first critical element is to have the metacarpal reduced on the trapezium and rotation correct so that the fracture is reduced. I usually then percutaneously fix the metacarpal to the trapezium and don’t necessarily fix the fragment with the anterior oblique ligament attached. If there is residual displacement, I will open and fix, and if it’s a large enough fragment, I’ll put a screw across the fracture.

Dr. Freeland: OK. Screw fixation. Is there a time and place for either a transcutaneous screw or a screw with a very limited incision such as a portal-sized incision, maybe a centimeter with a few millimeters more or less.

Dr. Light: Yes, if there’s any displacement and there’s 30 or 40 percent of the articular surface is involved, then I will try to fix that fragment with a lag screw.
reduction. I have seen some of your presentations, however, that you’ve done through a limited incision, as I recall. And they’re very impressive.

**Dr. Freeland:** Dr. Light, when you open these, are you visualizing the joint?

**Dr. Light:** My goal is to obtain and then maintain a reduction. If I find that I can, with a limited exposure, secure the fragments with a pointed clamp and then fix them with a limited exposure, I’d be happy, but that happens infrequently.

**Dr. Freeland:** If you transect the ligament or capsular structures, do you repair them as part of your procedure?

**Dr. Light:** Yes.

**Dr. Freeland:** Have either of you, starting with Dr. Light, seen any problems from transecting the ligament or capsular structures, any early or late problems from that?

**Dr. Light:** I’m not aware of any.

**Dr. Palmer:** I’m not either.

**Dr. Michlovitz:** In your opinion, would you use screw fixation to get someone back to play earlier and to begin earlier motion?

**Dr. Freeland:** I think that the stable fixation with the screw as opposed to Kirschner wire splinting, does allow you to proceed with your rehabilitation program both faster and probably more intensely, and may be important in the rehabilitation. Dr. Light, do you have any insight on that?

**Dr. Light:** That may be true, but I think that even with a screw, there’s enough vulnerability that the thumb needs to be protected against stress until there’s evidence of healing.

**Dr. Freeland:** Dr. Palmer?

**Dr. Palmer:** I would tend to immobilize whether I used screw fixation or the Kirschner wire. However, I often would let someone return to even a contact sport after this has been made stable with appropriate type of protection.

**Dr. Freeland:** What type of protection do you use for a playing or cast or splint for contact sports?

**Dr. Palmer:** I use a fiberglass cast, and would use a thumb spica cast in this instance. If I used a pin, I would cut the pin below the skin if I were planning on letting them go back to sport, and would pull it out five to six weeks following surgery. What I do for most of my athletes is put them in a Gortex cast, so that they can shower with the cast on. In order to play sports, padding is required. In the NFL, the cast has to be covered with a quarter inch of closed cell foam. In the NCAA, you can use a half inch of closed cell foam, and in high school, you can use a half inch of foam and written permission that they can play.

**Dr. Freeland:** Is this a universal rule? Are there variations from state to state?

**Dr. Palmer:** In 1994, the National Federation of High School Associations changed their rule. Actually, in 1993, Art Rettig and I reviewed both the NFL experience and 38,000 NCAA injuries that occurred and were treated with sports casts. We found no incidence in the high school players that we had been treating, the NCAA or the NFL where any player had been hurt or an opponent had been hurt by a playing cast. We also were unable to identify anybody that returned to sport with a playing cast on that made that fracture any worse or had delayed union because of it. So we took that information to the National Federation of High School Associations. In 1994, they changed the rules for all 50 states, that a playing cast is acceptable, if it is padded with one half inch of closed cell foam, and with written permission from the physician.

**Dr. Freeland:** Let me ask you how long do you tell a player that they’re going to be out, and if there’s a difference between skill players and non-skill players, and within skill players, as an example, a difference between throwers and receivers, and are there differences in different contact or impact sports, such as football, soccer, basketball, baseball, hockey. The definition of a skill player is one who touches the ball, as opposed to, a non-skill player is one who ordinarily doesn’t touch the ball at all.

**Dr. Palmer:** That’s a lot of questions, but let me try to answer. Definitely there is a difference in skill players and non-skill players. Any position that requires the use of the hand as a very important part of that position, or part on the team, is restricted with a cast. So a quarterback with a Bennett’s fracture is almost certainly out for six to eight weeks if it’s his dominant hand. If not, he can usually play. Receivers have some difficulty, but they can go back and attempt to play. Linemen are able to play with just about any injury to the upper extremity if it’s appropriately protected.

**Dr. Freeland:** How about differences in sports, such as football, soccer, basketball, baseball and hockey?

**Dr. Palmer:** The National Federation of High School Associations also

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**WHAT I THINK DEFINITELY NEEDS TO BE REPAIRED INITIALLY ARE ONLY [ULNAR COLLATERAL LIGAMENT] RUPTURES THAT HAVE A STENNER LESION.**

RONALD PALMER, MD

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continued on page 12
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AROUND THE TABLE

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allows soccer players in high school to participate with appropriate protective devices on the upper extremity. Hockey players with their gloves, protecting fractures is almost impossible, and normally, in my experience, hand fractures, except for those that can be buddy taped, normally have to be well on the way to healing before an orthotic device of some type can be made to fit in the glove. And once you can use an orthotic with adequate fracture protection that will fit in the glove, then they can return.

Dr. Freeland: How about the sports that have a handle and impact, like baseball, tennis and golf.

Dr. Palmer: It’s almost impossible to send somebody with a fracture that needs a cast to go back to any sport like racquet sports or baseball. Interestingly, though, I have allowed people to return to swimming with cast on, using the Gortex cast. I’ve also allowed basketball players to go back. They have to be very skillful, however, because the cast really does interfere with handling of the ball.

Dr. Freeland: So in order to play baseball or tennis or golf, you probably have to be completely over your injury and not shying on impact. Obviously, competitive players in particular, and even weekend warriors and high school players, one of the first things they’re going to ask you is, how long am I going to be out?

Dr. Palmer: With them, I would tell them that they need to have a healed fracture. What limits them is the type of immobilization used. That needs to be off, and they be pain-free with impact.

Earlier you asked when to allow players to go back with a sports cast. Originally, the criteria that I and many people in the country were using, for return to sports after an injury was, first of all, that
the swelling and local symptoms must have subsided at the site of the injury. Second, they have to have an appropriate protective device. The third criteria is that they have to be able to have contact without local pain or symptoms. I used to keep football players out routinely for two to three weeks after a stable fracture. I have people going back one to two days after a fracture at this point. In fact, I just reviewed about 200 cases of sports casts and the average date to return is about 2.4 days now following a stable fracture treated in a sports cast. With open reduction and internal fixation, with an unstable fracture, the criteria is that the fracture has to be made stable and those other criteria met. The average date is about three weeks to return to sport in a cast.

Dr. Freeland: Dr. Light, any differences between the dominant and nondominant hand?

Dr. Light: I think in some skilled situations there is some difference, but I generally don’t differentiate.

Dr. Freeland: Dr. Light, how do you guide the therapist in terms of starting rehabilitation with either K wires or screws? Is there a difference when you start motion and when do you go for strengthening, power, endurance and how do you phase them back into their sport?

Dr. Light: The first suggestion with thumb injuries is that you look at all three joints. I usually direct the therapist to begin rehabilitation of the uninjured joints, to try to recapture the motion there as soon as possible.

Dr. Freeland: Dr. Michlovitz, what techniques and methods do you use to regain mobility, and is there a difference between injured and uninjured joints in the thumb?

Dr. Michlovitz: Yes, there is. If we begin first with the uninjured joints of the thumb, I would be more aggressive in restoring mobility by making sure first that I stabilize the injured joint, either manually while I’m doing exercise with the athlete or with a splint the person would wear during exercise. To restore motion in a joint like the IP, for example, I could begin a patient with early joint mobilization where I passively maneuver the joint, and then teach the patient how to put themselves in a position that would hold them at end range of motion for 15 to 30 minutes a few times a day, using the concept of a low load prolonged stretch. With the injured joint, I would be more concerned about stability over mobility, particularly if there is an intraarticular component. I would have a tendency to use less passive motion with the person and have them go through a pain-free range of motion until it’s safe to stress the injured tissue. This would be approximately six to eight weeks following injury, before I would do any passive motion with them. Also, the therapist needs to be aware of where the injury occurred and what type of repair was done.

Dr. Freeland: Do you ever use hydrotherapy?

Dr. Michlovitz: I would have the patient use warm water at home. In the clinic, I’d have a tendency to use more local heat like paraffin, fluidotherapy, or a hot pack.

Dr. Freeland: Let’s say that we have a patient four weeks post-operatively. If Kirschner wires have been used, they’re removed. If they have screw fixation, it should be firmly fixed. We should have at least the early elements of healing, and now we’re able to initiate some early strengthening exercises. Is this a time to simultaneously start scar management and edema management as well?

Dr. Michlovitz: OK. I wouldn’t begin a strengthening program until the edema was under control. If someone started an activity and their hand swelled up, I would decrease the strengthening activity. When the athlete first came out of an immobilization device, if they had a fracture at the base of their thumb, I would stress strengthening activities that incorporated primarily the digits and not the thumb, and incorporate activities to increase strength of the wrist musculature. Once some pain-free range of motion is regained, then I would begin with pinch strengthening activities and activities that would involve a torque like gripping and turning. That would be the last in my progression, though, to actually strengthen the muscles around the thumb, then have the thumb used in a gripping and pinch activities.

Dr. Freeland: Is there a place for a dynamic assist splinting in the thumb?

Dr. Michlovitz: I think there is a place for dynamic flexion assist splinting. It’s more difficult to use if you have an injury at the base of the metacarpal than it is at the MP joint, and I more frequently will use that for people who have had an ulnar collateral ligament injury and have lost some flexion of the thumb.

Dr. Freeland: Extra-articular base of the thumb metacarpal fractures seem to occur frequently in contact and collision sports. They’re usually of either transverse or oblique configuration. The main question that I would have there is one of reduction and stability. If the fracture is displaced and unstable, and cannot be treated by a closed means, Dr. Palmer, what type of fixation do you prefer, and how long do you use it?

Dr. Palmer: Well, it depends on the nature of the fracture, whether it is a transverse fracture, which usually are not displaced and unstable in the thumb. Transverse fractures are at the base, in my experience, usually can be adequately treated with closed reduction. One can accept a good deal of angulation proximally, continued on page 14
usually up to 40 degrees of angulation at the base of the metacarpal. This will not affect function of the thumb.

Dr. Freeland: Suppose you were taking the cast or splint off, and you had some angulation within 40 degrees, but it was visibly apparent clinically, and the patient’s parents brought that to your attention and were concerned about it, would that influence your judgment in using any type of fixation for the fracture?

Dr. Palmer: If it were visibly apparent, I may consider altering my treatment, but usually it’s not visually apparent. I regard my function as trying to restore maximum function after an injury to the hand. I try to convince my patients that the reason to be more aggressive about the treatment is to improve function. But if I can’t improve function by opening or fixing the fracture, I don’t think it’s justified.

Dr. Light: I think with 30 or 40 degrees of angulation they do lose some thumb abduction. It’s not so much the athlete. If you have someone who plays the piano and really is dependent upon the full span of their hand, I would insist on a better reduction. But for most people, the subtle loss of span is not noticed.

Dr. Freeland: I think for most of us, if we have a simple extra-articular fracture, transverse or oblique, that we feel requires stabilization, most of us would prefer to use percutaneous pinning for three and a half to four weeks. Is there a place, Dr. Light, for open reduction and internal fixation?

Dr. Light: I think if you cannot obtain or maintain reduction with the percutaneous pin fixation, then I’d have no hesitation in proceeding to open reduction. But I think that’s unusual.

Dr. Freeland: After you start strengthening, is it important to place additional emphasis on strengthening and endurance exercises for the entire upper extremity, or even both upper extremities?

Dr. Palmer: Well, it depends on the nature of the injury. With the weight lifters, I always like them to return. I always tell them, first of all, don’t do what hurts. So if it hurts, modify how you are lifting, and be aware of the way you’re putting stresses across this thumb. Always start with a low weight and many repetitions and work up slowly.

Dr. Freeland: How soon do you get hand-injured patients back to lower extremity conditioning in terms of running and any other endurance exercises that involve general conditioning?

Dr. Light: I don’t think you suspend conditioning exercises.

Dr. Freeland: That brings up another issue, whether to leave the pins protruding through the skin, or cut them just underneath the skin, and should they be bent or not. Dr. Light, you’ve given us some insight on that. Dr. Palmer, what are your thoughts?

Dr. Palmer: My mentor, Dr. Frank McCue always cut pins below the skin. And if I’m going to let someone work out or participate in a sport where I’m worried about pin track care, I definitely cut them below the skin. The only problem that I’ve ever had with that is, and I do not bend them, I leave them straight, is you sometimes get what we call “proud flesh” that would develop over the tips of the pin, which is pretty unattractive when you first take the cast off. It usually goes away with time, however. Pulling the pin requires an incision or stab wound. In the non-athletes, or someone that I’m not worried about pin contamination, or not having them go back to sport, I leave them outside of the skin and bend them.

Dr. Freeland: Let’s move on to some of the ligament and joint injuries. Let’s start with the classic ulnar collateral ligament injury. I think that most people feel that type one sprains which are attenuation of the ligament and type two sprains which are partial tears without instability can be treated by closed methods and rehabilitated and protected pretty much in the way we’ve talked about fractures. The grade three sprain that has a complete tear and is unstable, what are the criteria for the diagnosis of that lesion, Dr. Palmer?

Dr. Palmer: It’s a difficult problem. I think I am somewhat out of the mainstream on this issue because what I think definitely needs to be repaired initially are only ruptures that have a Stener lesion. I think that one should try clinically to assess whether there is swelling under the adductor pollicis which may indicate the collateral ligament is sticking up proximal to the adductor retinaculum. It sometimes can be even palpable in that area. I try in most of these not to do stress x-rays initially because I don’t want to open the joint up and create a Stener lesion. I think that clinically you can tell if there seems to be a good deal of instability, and I tend to put those that I do not feel need acute repair into cast and have been very satisfied with five to six weeks of immobilization. These are Grade III tears, without a Stener lesion, and I don’t recall having had to operate on any that I’ve treated that way. The other ones, I think, need acute repair, and generally, it’s fairly obvious that they have gross instability. Most people feel that on a stress x-ray, 30 degrees of angulation is a definite indication for repair.
Dr. Freeland: Is that 30 to 35 degrees in both extension and flexion?
Dr. Palmer: I think either/or they should be done both in extension and flexion.

Dr. Freeland: Extension will test primarily the volar plate and flexion will test primarily the collateral ligament itself. Dr. Light, I’ve heard some people say that if you have 30 degrees of instability in either extension or flexion, and no feeling of an end point when you do the stress test, and this is further verified on stress x-rays, that you should open every complete ligament tear because of the concern of missing a Stener lesion if you don’t. How do you feel about that?

Dr. Light: I think one of the more interesting papers in recent years was the work of Jay Ryu from West Virginia. He routinely arthroscopes complete lesions and determines by arthroscopic visualization whether there is a Stener lesion. He has found that a number of complete lesions did not have a Stener lesion. In the cases in which there is a Stener lesion, he is able to tease the ligament back in place. He then simply pins the joint without doing a direct ligament repair. He has reported in a series of patients with good healing. The point from this experience is that if we can determine on patients who have a total tear, whether or not there is a Stener lesion, then we can be a little more selective in who is treated operatively. Techniques for visualizing the ligament to make that decision include ultrasound and MRI.

Dr. Freeland: So we’re making a greater effort now than we used to, to determine whether or not we have a Stener’s lesion prior to doing a surgical procedure, rather than at surgery. Dr. Palmer, if we find a Stener’s lesion, and we open the ulnar side of the joint, do you have any technical preference for the way that you repair that lesion which usually evolves off of

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1999 Application for Research Grants

Annual research awards will be made by the Research Committee of the American Association for Hand Surgery. Awards were established to further the purpose of the Association as stated in its Bylaws and to foster creativity and innovation in basic and/or clinical research in all areas pertinent to hand surgery.

Awards and Eligibility

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

Grant Application

Applications may be obtained from:
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Applications (original plus four copies) must be received by the committee chair no later than Friday, September 11, 1998, in order for the judging to be completed in time and the recipients to be announced at the Annual Meeting.

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

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

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

Mail Grant Proposals to

William Lineaweaver, MD
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the phalanx with either a very small fragment that cannot be restored, or the ligament itself?

Dr. Palmer: Yes, I do. I used to drill two holes, make a trough for the ligament and drill two holes and use a pull-out wire to button on the radial side. But over the last few years, I’ve been using an anchoring suture, and have found those to be very, very good. I always also try to reef the retinaculum.

Dr. Freeland: Louis Lane, I think, wrote an article at one point in time where he restored the ligament by using horizontal mattress sutures of 4-0 white Ethibon to the adductor tendon itself and reported very good results. Dr. Light, have you had any experience with that?

Dr. Light: No, I think that was Dr. Neviser who initially described that technique.

Dr. Freeland: For the chronic injury.

Dr. Light: Yes. I have not used it acutely. Acutely, I’m most interested in precisely restoring the anatomy, and particularly in restoring the anatomy to the hood. Because I believe that overtightening the hood has the potential for restriction of interphalangeal joint motion, I try to do an anatomic repair rather than plication.

Dr. Freeland: If there is a large enough fragment to restore, any preference or guidelines for fixation in terms of K wire, screws or other devices, any other wiring systems? Dr. Palmer?

Dr. Palmer: Usually with a small fragment, it’s very, very difficult to use a screw. I like to use a screw if I can because I think it gives excellent fixation, does not have to be removed, and can restore it anatomically. My preference would be to use a screw but I find that most often that’s not possible because of the size of the fragment, and I use K wires.
**Dr. Freeland:** Dr. Michlovitz, we have an ulnar collateral ligament that was repaired acutely in an athlete, in a throwing athlete, and at five to six weeks after surgery, he is out of his cast and that thumb is very stiff, and you’ve been instructed to see if you can get the edema and the motion improved. Any special thoughts or techniques in that regard?

**Dr. Michlovitz:** In that regard, if the edema is local for the joint, you could use retrograde massage with string wrapping. A compression wrap could be worn under the splint to help control the swelling. As far as increasing motion, if the physician felt that the stability of the repair was enough to do passive range of motion, I would begin that at that point, with manual passive range of motion without applying lateral stress while he’s doing it.

**Dr. Light:** Dr. Freeland, I’d like to comment that I don’t put a patient with collateral ligament repair in a cast. I manage them in a thermoplastic splint which, starting at 48 hours, they take off to exercise the carpal-metacarpal joint and the IP joint, and to begin to manage edema through some of the techniques we’ve just heard.

**Dr. Michlovitz:** At 48 hours after the repair?

**Dr. Light:** I tell the athletes that the pin will come out when they have regained full, active interphalangeal and carpal-metacarpal motion. This gives them a very clear end point and a rationale for the exercise. I think that if there is full IP and CMC joint motion at the time the pin is removed from the MP joint, that the patient has an easier time regaining motion at the MP joint.

**Dr. Freeland:** OK. Moving on to the topic of phonophoresis or iontophoresis and muscle stimulation, is there any place for that in rehabilitation of joint and ligament injuries of the thumb, or even fractures?

**Dr. Michlovitz:** If there is a swollen thumb, perhaps using iontophoresis with dexamethasone may be beneficial to help control the swelling. There is not much evidence, though, in any of the therapy literature at this point, that phonophoresis has a positive effect on the conditions that we’ve been trying to use it for. I do not use either of those very often. There are some therapists who would use iontophoresis for swelling control.

**Dr. Freeland:** Let’s move on to the radial collateral ligament. Although there’s no Stener’s lesion, let’s again discuss the injury that has a complete ligament tear with instability and 30 degrees or more of angulation on stress testing and no end point on stress testing. Dr. Palmer, how do you treat those?

*continued on page 19*

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AAHS Affiliates Represented at ASHT Meeting

Hand Therapy Committee members Laura Kearney, OTR/L, CHT and Colette Jewell, OTR, CHT were on hand at the American Society of Hand Therapists Annual Meeting, September 18-21 in San Diego as representatives for AAHS. From our table in the Exhibit Hall we greeted current AAHS affiliate members and introduced others to the membership benefits we enjoy. Information regarding Affiliate Membership, the Vargas Award, the Carpal Tunnel Syndrome Seminar and Annual Meeting were distributed. Therapists (especially those on the West Coast) expressed enthusiasm about the Annual Meeting in Scottsdale.

In addition, we were delighted to have AAHS recognized during the Opening Ceremony remarks and included in the Business Meeting. The ASHT Annual Meeting continues to provide excellent educational opportunities for therapists. For our organization, it increased our visibility and will hopefully lead to new membership.

Hand Therapy Profile

Jennifer Thurn, OTR, CHT

Personal: Loves travel, movies, reading, long walks, camping, gardening and spending time with friends.

Education: B.S. in Biology and Occupational Therapy from the University of Minnesota. Certified Hand Therapist since 1991.

Employer: Fairview-University Hospital, University Orthopaedics Hand Center. Supervisor Hand Therapy. Our clinic sees a wide variety of upper extremity problems, ranging from simple fractures, tendon lacerations and CTD’s, to complex reconstructions, tendon transfers for quadriplegics, peripheral nerve injuries, and children with congenital anomalies.

AAHS Involvement: Has been an affiliate member of AAHS for 10 years. Coproduced a poster session for 1994 AAHS Annual Meeting. Has tremendously enjoyed AAHS sponsored educational opportunities as time and funds have permitted.

Best Part of My Job: Seeing the happiness and joy on peoples’ faces when they are finally able to return to activities they’ve enjoyed previous to their injuries. Meeting and working with people from a wide variety of cultures and backgrounds.

Major Accomplishment: Being instrumental in the design and staffing of two different hand clinics. Having the opportunity to teach at state and local levels and present research on a national level.

Greatest Challenges: Identifying the needs of, and effectively communicating with, people from different cultural backgrounds, especially with those that don’t speak English. Creating a balance between work and home life.

Three Words that Describe Me: Steady, inquisitive, friendly.

Membership Drive Contest Winner

Cynthia Cooper, from Scottsdale, Arizona, was the winner of the First Annual Membership Drive Contest. Cynthia recommended three new applicants for affiliate membership in AAHS. Because of Cynthia’s efforts to introduce new members to AAHS, she has won free attendance at this year’s Annual Conference in Scottsdale! Way to go Cynthia!

Membership Drive Winner Cynthia Cooper

As a reminder to all Affiliate members, start encouraging your colleagues to join AAHS and you may win next year’s contest prize—free attendance to the AAHS Annual Conference in Hawaii! For details, contact Cathy Hay at the AAHS Central Office at 847-228-9758.
Hand Therapy Pre-Conference Seminar

Wednesday, January 7

"Tendons: Old Problems...New Solutions"

7:00-8:00 am  Registration
8:00-8:15 am  Introduction
  Shirley Cohen, OTR/L, CHT
  Sr. Co-Chair, Committee for Hand Therapy
8:15-8:45 am  A Practical Review of Tendon Anatomy
  Anthony Smith, MD
8:45-9:15 am  The Trouble with Tendons...
  Jules Shapiro, MD
9:15-9:45 am  Upper Extremity Tendinitis: Overview of
  Common Diagnosis and Provocative Questions
  Regarding Immobilization
  Cynthia Cooper, MFA, MA, OTR/L, CHT
  Lori Falkel Carbojaj, PT
9:45-10:15 am  Four Staged Flexor Tendon Repair
  Daniel Nagle, MD
10:15-10:30 am  Break
10:30-11:00 am  Early Controlled Active Motion Protocols for
  Flexor Tendon Repairs
  Linda Klein, OTR, CHT
11:00-11:30 am  Tendon Adhesions: Modalities and Methods
  That Work
  Lorraine Paquette, MAEd, OTR, CHT
11:30 am-12:00 pm  Flexor Tendon Grafting
  Norman Weinzeig, MD
12:00-12:15 pm  Questions
12:15-1:30 pm  Affiliate Members Luncheon
  All attendees are welcome
1:30-2:00 pm  Therapist Management of Extensor Tendon
  Repairs
  Julianne Howell, MS, PT, CHT
2:00-2:30 pm  Splinting Tendon Injuries
  Cindy C. Ivy, M.Ed, OTR/L, CHT
  Karyn J. Fletcher, OTR/L, CHT
2:30-3:30 pm  Manual Edema Mobilization: New Edema
  Reduction Rationale
  Sandra Artzberger, MS, OTR, CHT
3:30-3:45 pm  Break
3:45-4:45 pm  Challenging Case Studies: A Panel Discussion
  Moderator: Julianne Howell, MS, PT, CHT
  Panel: Sandra Artzberger, MS, OTR, CHT
  Cynthia Cooper, MFA, MA, OTR/L, CHT
  Linda Klein, OTR, CHT
4:45-5:00 pm  Questions

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Dr. Palmer: If there’s a Grade III tear, again, I have treated them conservatively. It’s funny. With radial collateral ligaments, you don’t seem to see them acutely as much as you do ulnar collateral ligaments. I have treated radial collateral ligaments in a thumb spica cast, and have felt that I had successful treatment. That’s contrary to what some of the literature says.

Dr. Freeland: Let’s say, for example, that a lineman sustains a complete tear of either the radial or the ulnar collateral ligament in September, and he’s able with taping and other protective devices to complete the season. He’s unstable four months following his injury. How would you decide whether to do some type of soft tissue stabilization or ligament reconstruction as opposed to considering an arthrodesis in either of those injuries?

Dr. Palmer: I always try a soft tissue reconstruction before an arthrodesis, and I can’t recall doing an arthrodesis for instability of the joint. For later degenerative changes, but not for instability.

Dr. Light: After one year, there usually are degenerative changes on direct inspection of the articular surface, particularly in ulnar collateral ligament tears, because of the rotation and the abutment of the dorsum of the subluxed phalanx against the metacarpal head. Usually beyond a year, I recommend arthrodesis. I don’t have any experience with a dynamic tenodesis. I would echo Dr. Palmer’s lack of enthusiasm for tendon secondary repairs. My experience has been that they end up pretty stiff.

Dr. Freeland: I think we’ve had a really outstanding discussion and I would like to thank each of you very much for your participation.
American Association for Hand Surgery Calendar

For information contact:
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1997
November 21-23
Carpal Tunnel Syndrome: An In-Depth Review
Sheraton Bal Harbour
Bal Harbour, FL
(presented with The American Academy of Orthopaedic Surgeons)

1998
January 7-10
28th Annual Meeting
The Phoenician Resort
Scottsdale, AZ
(followed by ASRM's Annual Meeting)

May 24-28
7th Congress of the International Federation of Societies for Surgery of the Hand
Vancouver Trade and Convention Centre
Vancouver, British Columbia, CANADA

May 28-30
IPSSH Post-Congress Tour (sponsored by AAHS)
Victoria, CANADA

1999
January 13-16
29th Annual Meeting
Hilton Waikoloa Village
Kamuela, Hawaii, HI

2000
January 5-8
30th Annual Meeting
Loews Miami Beach
Miami Beach, FL

Other Meetings

1998
January 11-15
American Society for Reconstructive Microsurgery
The Phoenician Resort
Scottsdale, AZ

March 19-23
American Academy of Orthopaedic Surgeons Annual Meeting
New Orleans, LA

April 3-7
AOTA Annual Meeting
Baltimore, MD

May 22-24
American Society for Peripheral Nerve 8th Annual Meeting
Vancouver, CANADA
(immediately proceeding the IPSSH Meeting—call 804-749-3943 for more info)

September
ASHT
New Orleans, LA

September 9-12
American Society for Surgery of the Hand Annual Meeting
Minneapolis, MN

October 3-7
ASPRS/PSEF/ASMS Annual Meeting
Boston, MA

1999
International Confederation of Plastic Reconstructive and Aesthetic Surgeons (IPRAS)
San Francisco, CA

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Christine B. Novak PT
One Barnes Hospital Plaza
East Pavilion, Suite 17424
Saint Louis MO 63110