A Publication of
the American
Association for
Hand Surgery
Summer 2006

HAND SURGERY
QUARTE Rally

AAHS Vargas International Hand Therapy Teaching Award Celebrates Its 10th Anniversary

by Maureen Hardy, PT, MS, CHT

“Twenty years from now you will be more disappointed by the things you didn’t do than by the ones you did. So, throw off the bowlines, sail away from the safe harbor, catch the trade winds in your sails. Explore.”

—Mark Twain

Did you ever miss an opportunity that you lived to regret? At the 1987 AAHS Annual Meeting, Puerto Rico, the Ad Hoc Committee for Hand Therapy Development held an inaugural lunch forum. Our intent was to recruit therapists in attendance to join the AAHS, under the new affiliate category, and spread the word of this unique professional opportunity. To our surprise, one physician joined us, who happened to be the Local Arrangements Chair. Following the luncheon, this physician approached and introduced himself to Juli Howell PT MS, Nancy Rosenblum Branz PT MS, (ad hoc committee) and Maureen Hardy PT MS; he was Dr. Miguel Vargas.

Dr. Vargas explained, that although he applauded the concept of surgeons and therapists exchanging information about hand management at professional conferences, most of this information was impractical for therapists practicing in countries with limited resources. He invited us to leave the meeting and tour some of the local therapy clinics. Due to our commitments at this meeting, we declined his polite invitation—oh, REGRET!

Tenacity must have been one of Dr. Vargas’ strong points. At the 1991 Annual Meeting in Vancouver, the faculty and AAHS Board of Directors were

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The Vargas Award Travelogue

1996: Thailand
Lynne Feehan MScPT CHT, Somprasong Songcharoen MD

1997: Kenya
Colette Jewell OT CHT, Paul Weeks MD

1998: Venezuela
Lynn Bassini MA OT CHT, Alan Freeland MD

1999: Egypt
Katherine Schofield OT CHT, Nash Naam MD

2000: Lithuania
Karen Henahan OT CHT, Terry Light MD

2001: Uganda
Gail Groth MHS OT CHT, Scott Kozin MD

2002: USA
Veronica Fernandez PT from Caracas, Venezuela

2003: Navajo Nation Indian Reservation, Arizona
Paul Brach PT CHT, Susan Michlovitz PT PhD, Brian Adams MD, Lee Osterman MD

2004: Guatemala
Sharon Dest PT CHT, Paula Galaviz MS OT CHT, Miguel Pirela-Crus MD, Mukund Patel MD, Warren Schubert MD

2006: Romania
Donna Pendleton MS PT CHT, Lorna Ramos MA OTR

1998: Left to right, Dr. Oscar Vargas, Lynn Bassini MA OTR CHT, Dr. Alan Freeland MD, and Tati, widow of Dr. Miguel Vargas.

“It is an honor for my family and myself that the AAHS has chosen to name this award in memory of my husband.”

—Leonor M. Vargas 1996
A New Kid on the Block

Earlier this year, the AAHS Board, under the leadership of Susan MacKinnon, made a major decision: to launch a new peer-reviewed journal in hand surgery. The new journal, aptly titled HAND, will be published by Springer. The first issue of this quarterly journal is due out later this year. Of course, a subscription is a benefit of AAHS membership.

Under the able leadership of inaugural Editor Elvin Zook, MD, Associate Editor Chris Novak, PT, and a stellar cast of surgeons and therapists on the editorial board, HAND will publish cutting edge clinical and basic research, technical tips, book reviews, letters, and scientific reviews covering the broad range of hand surgery and rehabilitation. The journal will appear online as well as in print. Articles are already in press.

Why a new journal? Well, we have not had a new journal in hand surgery in some time. The British (now British and European) Journal of Hand Surgery began life as THE HAND, in the early 60's, followed by the American JOURNAL OF HAND SURGERY in 1976. An Asia-Pacific journal, HAND SURGERY, has had an on and off existence for the past decade, but has never caught on in the US. The JOURNAL OF HAND THERAPY launched in 1987, but is limited to topics of interest to hand therapists. All the while the number of hand surgeons and hand therapists has continued to grow. The time is right.

At first, the new journal may not appear in MEDLINE, Pub MED, and other familiar sources. But, if the journal prospers, as I think it will, listing (often retroactive, so the early numbers get included as well) is likely to follow soon.

Want to submit an article? For the moment, online submission is not possible, but it's still not hard. Manuscript submission can be either by email or hard copy to the managing editor at Springer, Ms. Yvonne Chan. Her address is listed below. You will need to include a cover letter listing the corresponding author’s full name, mailing address, telephone, fax, and e-mail.

Yvonne Chan
Springer
233 Spring Street
New York, New York 10013
Tel: (212) 460-1661
Fax: (212) 647-1898

Copyright on all accepted manuscripts will be held by the American Association for Hand Surgery, so it really is our journal. A copyright transfer statement must be signed by all authors, expressly transferring copyright to the AAHS in the event the manuscript is accepted for publication. A sample copyright agreement is included in this issue.

What will happen to HSQ? Probably not much (unless you want it to). HSQ content is quite different from that envisioned for HAND. HAND will have scientific content; HSQ will continue to feature AAHS news, editorials, member profiles, and such features as Coding Corner and the ever popular Around the Hand Table. So sit back and enjoy a double benefit of AAHS membership. HSQ, HAND, and you. What a combination! Tell your friends.

Springing Ahead

This has certainly been a busy and productive spring. In March, at the annual meeting of the AAOS, held in Chicago, I was invited to a Presidential line meeting. The Academy is concerned hand surgeons do not actively participate in their annual meeting. I advised them it was my opinion the reason for this is because the specialty societies, particularly AAHS and ASSH, fulfill the academic requirements for its members at their annual meetings. Certainly, AAOS and ASPS provide valuable resources to its members at their annual meetings. However, the special interest of hand and upper extremity surgery seems to be better met at those specialty society organized meetings. AAOS is soliciting our organization to become more actively involved in educational activities through their organization. They have suggested we consider co-sponsoring with their organization for any additional meetings we might have throughout the year. Our parent organizations have a great deal to offer in resources. Consideration should be given if such arrangements are mutually beneficial to both organizations.

In April, Central Office and I made a site visit to Puerto Rico. This was in anticipation of our annual meeting in January. We were pleased to find a toll way from San Juan to the East Coast area of Puerto Rico had recently been completed. This markedly improves the transportation time from the airport to the Westin Rio Mar Beach Resort. At the Resort, a multi-million renovation has essentially been completed. This
FROM THE PRESIDENT

The hotel is trying to make our stay as enjoyable as possible. We had the opportunity of arranging a number of entertainment venues. I believe the entertainment arranged will make the entire experience at the annual meeting enjoyable for both the participants and their families. I had hoped to try one of the two golf courses the last afternoon I was in Puerto Rico. However, my wife advised me I had not spent any time with her. She did not look favorably upon me spending the afternoon on the golf course. Therefore I had to breakdown and spend the afternoon on the beach with her, drinking Piña Coladas. What a sacrifice!

I just returned from the May meeting of the National Orthopedic Leadership Conference held in Washington, D.C. This also included the Board of Specialty Societies’ meeting, which was formally COMSS. During the conference, there was a panel entitled “update and feedback on hand surgery scopes’ issue”. The panel was chaired by the Chairman of BOS. The panel members for hand surgery were Dr. Dave Lichtman and myself, representing ASSH and AAHS respectively. Also, the President of the Orthopaedic Trauma Association, the President of the American Shoulder and Elbow Surgeons, and the President of the American Orthopaedic Society for Sports Medicine were on the panel. The primary purpose of this panel was to discuss proposed revisions to the program requirements for graduate medical education in hand surgery. What was of primary concern was a revision in the proposal that fellowships may include “the following areas of upper extremity surgery may be included in a hand surgery fellowship, but not required, if included, the quality and quantity of the experience should enhance the educational exposure in the area outlined. #1. Elbow and shoulder trauma reconstruction injuries. #2. Brachial plexus reconstruction. #3. Microsurgical reconstruction of arm, elbow, and shoulder.” This essentially boiled down to a turf battle over the fact shoulder may be included in the program for fellowship training in hand surgery. The primary objection came from the President of the American Shoulder and Elbow Surgeons, feeling since hand surgery has a CAQ, hand fellowship trained surgeons may be recognized as the experts in shoulder surgery. As a point of interest, ASES does not have a CAQ. Dr. Lichtman and I essentially agreed on everything regarding the issues. We are in agreement, if hand fellowship programs have the faculty and facilities to provide a quality exposure in shoulder surgery, they certainly should be allowed to provide the experience. We also feel the Fellows should be able to include these cases in their surgical lists and count toward their fellowship training. It was pointed out to the audience, at least in our experience, the CAQ has not been of significant benefit in recognizing the holder of the CAQ. It seems its primary benefit may be it is a requirement to become a member of ASSH. Beyond that it may only be of value in being mentioned in the Curricula Vitae for medical legal issues. The President of the Orthopaedic Trauma Association was very complimentary to hand surgeons in general. He pointed out to the audience how important hand surgeons’ involvement in the trauma settings is. He also pointed out how undervalued the services provided by hand surgeons are and how low their reimbursement seems to be. I don’t think they will be willing to decrease their reimbursement to increase reimbursement for hand surgery. I found some of the floor comments fairly offensive. Some members of the audience who specialize in foot and ankle surgery were comparing hand surgeons to podiatrists. The podiatrists want to expand their services more proximally into the lower extremity. I found it offensive hand surgeons with medical training, who are certainly qualified to operate on the entire body, are compared to podiatrists.

The bottom line, however, is this panel was more a courtesy to have the opportunity to talk about this issue. The sanction by AAOS is not required for the proposed revisions to the program requirements for graduate medical education in hand surgery. My recommendation continued on page 4
Certainly would be to proceed with those revisions.

In all, this has been an interesting and busy spring. Central Office and I are currently preparing for our mid-year meeting. We hope to have a program for this year in Puerto Rico that parallels the great meeting given last year in Tucson by Sue McKinnon and her team.

I look forward to seeing everyone in Puerto Rico in January. Please come participate and pick up “the hand treasures of the Caribbean”.

FROM THE PRESIDENT

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Brachial Plexus Surgery Course

Advances in Brachial Plexus Surgery: A Surgical Skills Course was sponsored by the AAHS and held at the Mayo Clinic, Rochester, MN, between April 28 and 30. The three-day surgical skills course, chaired by Alexander Y. Shin, MD and co-chaired by Allen T. Bishop, MD and Robert J. Spinner, MD, was attended by 74 participants. These participants traveled from Turkey, Japan, South Korea, Australia, England, Europe and throughout the United States to attend this course. The diverse background of orthopedic surgeons, neurosurgeons, plastic surgeons, residents, fellows and ancillary staff made for exciting case discussions and conversations that were carried on even after the last lecture was concluded. A world renowned surgical faculty including Susan Mackinnon, MD, David Kline, MD, Christophe Oberlin, MD, David Chuang, MD, Scott Wolfe, MD, Scott Kozin, MD, Allen Belzberg, MD, Rajiv Mihda, MD, Milan Stevanovic, MD, Mike Wood, MD, and Scott Steinmann, MD, helped make the course an overwhelming success.

Over the three day course, the 74 participants performed supraclavicular, infraclavicular explorations, intraplexal nerve grafting, vascularized ulnar nerve transfers, intercostal nerve harvest, Oberlin procedures, as well as late reconstructive procedures. Concurrent to the surgical skills portion was the lecture series which included spectacular lectures from the faculty with interactive case discussions.

We would like to thank Integra, Synovis and Baxter for sponsoring events during the course. Finally, a very special thank you to Alice Hayner from the AAHS office and Michelle Kircher, RN, the Mayo Clinic Brachial Plexus Team Research Coordinator, for all their behind the scenes contributions that made the course run so smoothly.
On Solid Ground

I present the treasurer’s report for the year ending December 2005 and am happy to report that despite Katrina and having to change venues for our 2005 annual meeting in mid-stream, the hand association remains on solid ground. This is a tribute to the leadership of our past president, Susan Mckinnon, president Ron Palmer, president-elect Brad Meland and vice-president Scott Kozin who continue to watch over the management and assets of the AAHS. In addition, our Central Office under the leadership of Laura Downes-Leeper continues to provide excellent management services. Lastly, we again owe gratitude to Jeff Palmer with Smith Barney who continues to manage our investments in this volatile market.

Despite a slight decrease in membership, dues income remains relatively stable. Thanks to the hard work of many, our late change of venue from Florida to Puerto Rico for the 2005 annual meeting was quite successful and meeting income exceeded the prior year. However, due to the increased expenses, especially the audiovisual costs, there was a slight loss from the meeting ($7271). Investment income again declined, however our portfolio continues to perform better or about equal to the leading indices and 2006 should be a better year.

With the exception of Board and Committee costs, expenses continued to rise as shown in Table 2. However most expenses were only slightly over budgeted amount. As previously noted meeting costs in Puerto Rico were noticeably higher than prior years.

Despite the increasing expenses and limited revenue sources, the association remains financially solid as seen in Table 3. Obviously, with a fairly limited income basis, mostly from dues and the annual meeting, it will be necessary to closely monitor expenses in the years to come. The executive committee encourages all members to stay active in the organization and to invite new members from their fellow hand surgeons and therapists.

As noted in last year’s report, I am also the treasurer of the Hand Surgery Endowment. The endowment board has met several times over the past year to develop a strategy for continued growth with hopes that in the near future it can become self-sustaining. With the help of the newly enlisted management corporation from the Illinois State Medical Society, an aggressive budget has been set forth. Also, in addition to passionately encouraging contributions from the association leadership, HSE president Alan Freeland and the HSE board has enlisted an outside consultant to devise a strategy for growth over the next several years. Both individual and corporate donations have increased and the HSE assets are now over $300,000. Keep up the good work!

If you have any questions or concerns regarding the financial status of the AAHS or the HSE, please feel free to contact me or the Central Office.

Repectfully submitted,
Richard E. Brown, MD, FACS
AAHS Treasurer

Table 1

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<th>Income</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
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<td>Dues</td>
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<td>$185,120</td>
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<td>Annual Meeting</td>
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<td>$251,527</td>
<td>$223,219</td>
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<td>Net Annual Meeting</td>
<td>$29,679</td>
<td>$34,871</td>
<td>$22,073 ($7,271)</td>
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<td>Investment Income</td>
<td>($91,327)</td>
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Table 2

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<td>$216,656</td>
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<td>$152,513</td>
<td>$159,479</td>
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<td>$181,620</td>
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Table 3

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<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
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<td>TOTAL INCOME</td>
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<td>$633,875</td>
<td>$502,882</td>
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<td>TOTAL EXPENSES</td>
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<td>NET INCOME</td>
<td>($58,481)</td>
<td>$119,217</td>
<td>($75,340)</td>
<td>($1,071)</td>
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<td>NET ASSETS</td>
<td>$895,993</td>
<td>$985,570</td>
<td>$1,004,627</td>
<td>$997,605</td>
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Off to a Good Start — Give and Go

The Hand Surgery Endowment’s “Campaign 2006 and Beyond” has gotten off to a good start with 91 American Association for Hand Surgery (AAHS) members having contributed $51,000 to date. Twenty-five members have contributed $1000 or more. We have corporate support. We hope to raise $100,000 this year to continue to support our excellent Annual Meeting and year-round member educational benefits, including web site (www.handsurgery.org) continuing education and international humanitarian outreach programs.

AAHS President Ron Palmer and Program Chairmen Lee Osterman and Jorge Orbay are lining up commercial sponsorships and exciting guest speakers for our 2007 Annual Meeting in Puerto Rico. The newly formed La Federation De Mano will join us at the Annual Meeting, enriching our educational, cultural, and personal experiences. Miguel Saldana and Allen Van Beek are developing future humanitarian outreach programs with our fellow hand surgeons in Mexico and Peru.

Penultimate Past-President Richard Berger was instrumental in initiating AAHS co-sponsorship with the American Society for Surgery of the Hand for Specialty Day at the American Academy of Orthopaedic Surgery Annual Meeting in Chicago this year. The AAHS and Editor-in-Chief, Elvin Zook, will introduce our new journal, Hand, this summer.

These are just some of the initiatives that will strengthen and advance our educational opportunities and year-round value for AAHS members. The AAHS is on a great trend, improving and moving forward. Funds from the HSE support these efforts, stabilize costs, and assure the future. The HSE appreciates the continuing generosity and support of our membership. Give tax-deductible dollars to the HSE and go to the AAHS meetings and web site. Join the programs to Mexico and Peru. We will let you know the details as they develop. Publish in our new journal. Keep us on the cutting edge.

Alan Freeland, MD
President, HSE

2007 Application for Research Grants

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

Grants and Eligibility

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

Grant Application

Applications may be obtained from the AAHS website at www.handsurgery.org, or, you can call 312-236-3307 to request a copy. Applications (an original plus seven copies) must be received by the committee chair no later than Monday, November 6, 2006, 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

Michael Neumeister, MD
American Association for Hand Surgery
20 North Michigan, Suite 700
Chicago, IL 60602
A new program was introduced at the end of last year, featuring AAHS members who have offered to teach their expertise in specific areas. Please take advantage of their academic generosity (see listing below). It is designed to let our members continue to learn the way we were taught, as residents and fellows, in the clinic and operating room with a surgical mentor. For more information, including to register as a mentor, please contact the AAHS Central Office.

AAHS Mentor Volunteers

<table>
<thead>
<tr>
<th>NAME</th>
<th>EMAIL OR PHONE</th>
<th>PROCEDURE(S)</th>
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</thead>
<tbody>
<tr>
<td>R. D. Beckenbaugh, MD</td>
<td><a href="mailto:beckenbaugh.robert@mayo.edu">beckenbaugh.robert@mayo.edu</a></td>
<td>Technique of pyrocarbon arthroplasty of the thumb carpometacarpal and metacarpophalangeal and PIP joints of the digits</td>
</tr>
<tr>
<td>Richard Berger, MD, PhD</td>
<td><a href="mailto:berger.richard@mayo.edu">berger.richard@mayo.edu</a></td>
<td>Wrist surgery</td>
</tr>
<tr>
<td>Allen Bishop, MD</td>
<td>Mayo Clinic 507-284-4149</td>
<td>Brachial plexus reconstruction, carpal vascularized bone grafts and microvascular free tissue transfers</td>
</tr>
<tr>
<td>James Chang, MD</td>
<td><a href="mailto:changhand@aol.com">changhand@aol.com</a></td>
<td>Dupuytren’s; thumb reconstruction; flexor tendon surgery; trapezial excision arthroplasty; and medial epicondylectomy</td>
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<tr>
<td>Kevin Chung, MD</td>
<td><a href="mailto:kecchung@med.umich.edu">kecchung@med.umich.edu</a></td>
<td>Rheumatoid and congenital</td>
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<tr>
<td>E. Gene Deune, MD</td>
<td><a href="mailto:egdeune@jhmi.edu">egdeune@jhmi.edu</a></td>
<td>Congenital hand anomalies and upper and lower extremity reconstruction for deficits due to trauma, cancer resection or neurological disorders (i.e. brachial plexus)</td>
</tr>
<tr>
<td>Scott H. Kozin, MD</td>
<td><a href="mailto:SKOZIN@shrinenet.org">SKOZIN@shrinenet.org</a></td>
<td>Pediatrics</td>
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<tr>
<td>Don Lalone, MD</td>
<td><a href="mailto:drdonlalone@nb.alb.com">drdonlalone@nb.alb.com</a></td>
<td>Wide awake approach to hand surgery</td>
</tr>
<tr>
<td>W. P. Andrew Lee, MD</td>
<td><a href="mailto:leewp@upmc.edu">leewp@upmc.edu</a></td>
<td>Post traumatic hand reconstruction; mini incision carpal tunnel release</td>
</tr>
<tr>
<td>William Lineaweaver, MD</td>
<td><a href="mailto:wlineaweaver@surgeryumsmed.edu">wlineaweaver@surgeryumsmed.edu</a></td>
<td>Business practices</td>
</tr>
<tr>
<td>Susan Mackinnon, MD</td>
<td><a href="mailto:mackinnons@wustl.edu">mackinnons@wustl.edu</a></td>
<td>Ulnar nerve surgery</td>
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<tr>
<td>Nash Naam, MD</td>
<td><a href="mailto:dnaam@handdocs.com">dnaam@handdocs.com</a></td>
<td>SLAC wrist reconstruction; vascularized bone graft in treating scaphoid nonunions; ulnar shortening &amp; radial shortening; PIP &amp; MP joint arthroplasty; LRTI; arthroscopy of the CMC joint of the thumb</td>
</tr>
<tr>
<td>Daniel J. Nagle, MD</td>
<td><a href="mailto:OOGIEN@aol.com">OOGIEN@aol.com</a></td>
<td>Wrist arthroscopy and endoscopic carpal tunnel release</td>
</tr>
<tr>
<td>Michael Neumeister, MD</td>
<td><a href="mailto:mneumeister@siumed.edu">mneumeister@siumed.edu</a></td>
<td>Basilar joint arthroplasty; peripheral nerve decompression</td>
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<tr>
<td>Jorge Orbay, MD</td>
<td><a href="mailto:jlorbay@aol.com">jlorbay@aol.com</a></td>
<td>Wrist fractures mentorship</td>
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<tr>
<td>A. Lee Osterman, MD</td>
<td><a href="mailto:loster51@bellatlantic.net">loster51@bellatlantic.net</a></td>
<td>Advanced wrist arthroscopy and small joint arthroscopy. Can also mentor a topic such as DRUJ problems, or wrist fracture.</td>
</tr>
<tr>
<td>Julian J. Pribaz, MD</td>
<td>Harvard Medical School 617-732-6390</td>
<td>Soft tissue reconstruction; microsurgical reconstruction; spare parts surgery and extremity reconstruction</td>
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<tr>
<td>Michael Raab, MD</td>
<td><a href="mailto:mikeraab1@earthlink.net">mikeraab1@earthlink.net</a></td>
<td>Corrective osteotomy (volar or dorsal) of distal radius malunion with iliac crest bone grafting</td>
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<tr>
<td>Jaiyoung Ryu</td>
<td><a href="mailto:jryu@adelphia.net">jryu@adelphia.net</a></td>
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<tr>
<td>David Slutsky, MD</td>
<td><a href="mailto:d-slutsky@msn.com">d-slutsky@msn.com</a></td>
<td>Wrist arthroscopy and arthroscopic repair of dorsal radiocarpal ligament tears; intra-articular distal radius fractures</td>
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<tr>
<td>Thomas Tung, MD</td>
<td><a href="mailto:tungt@wustl.edu">tungt@wustl.edu</a></td>
<td>Brachial plexus</td>
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<tr>
<td>Joseph Upton, MD</td>
<td><a href="mailto:jupton3@earthlink.net">jupton3@earthlink.net</a></td>
<td>Congenital hand surgery</td>
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<tr>
<td>Elvin Zook, MD</td>
<td><a href="mailto:ezook@siumed.edu">ezook@siumed.edu</a></td>
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Tendonopathies and Dupuytrens Contracture
Peter M. Murray, MD

Compression Neuropathies & CRPS
Daniel J. Nagle, MD

Thumb Basal Joint Arthritis, Wrist Arthritis, Kienbock's Disease
Matthew M. Tomino, MD, MBA

Inflammatory Arthritis of the Hand and Wrist
Brian D. Adams, MD

Distal Radius Fractures
Peter J. L. Jebson, MD

Distal Radio-Ulnar Joint
Brian D. Adams, MD

Scaphoid Fractures and Non-Unions
Peter J. L. Jebson, MD

Carpal Instability
Richard A. Berger, MD, PhD

Metacarpal and Phalangeal Fractures
Stephen D. Trigg, MD

Extensor Tendon Injuries
Kevin J. Renfree, MD

Flexor Tendon Injuries
Kevin J. Renfree, MD

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

Congenital Hand Differences
Scott H. Kozin, MD

Tumors of the Hand and Wrist
Edward A. Athanasiou, MD

Peripheral Nerve Injury and Reconstruction
Michael B. Wood, MD

Tendon Transfers
Michael B. Wood, MD

Soft Tissue Coverage of the Hand
William C. Pederson, MD

Vascular Disorders of the Hand/Reimplantation
Peter M. Murray, MD

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A must have resource.

Purchase this special limited edition DVD and put the entire 2006 Comprehensive Hand Surgery Review Course at your fingertips. This invaluable resource includes faculty presentations of 18 topics covered on board examinations, the hand surgery certification examination and resident in-training examinations. Recorded during the AAHS 2006 Annual Meeting, it’s a resource you’ll turn to over and over again.

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

*This DVD will operate only in a computer’s DVD drive.

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Order by Phone 312-236-3307
Order by Fax 312-782-0553
Order by Mail American Association for Hand Surgery 20 N. Michigan Ave. Suite 700 Chicago, IL 60602

Form of Payment (circle one):

Cash
Check
Credit Card

Credit Card Number
Exp.

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Thumb Basal Joint Arthritis

Arthritis was a topic of discussion for one instructional and two review courses at the AAHS Annual Meeting in January. HSQ has invited several of the presenters from the meeting to bring their insights and expertise to this edition of the Around the Hand Table. The moderator for this discussion is Miguel Saldana, MD, Hand and Microsurgery Association, San Antonio, TX. He is joined by Brian Adams, MD, Orthopedic Surgery, University of Iowa, Iowa City, IA; Alejandro Badia, MD, FACS, Miami Hand Center, Miami, FL; Nash Naam, MD, FACS, Clinical Professor of Plastic and Reconstructive Surgery, Southern Illinois University and Southern Illinois Hand Center, Effingham, IL; and Paul Brach, MS, PT, CHT, Facility Director, Hand and Upper Extremity Rehabilitation Program, Centers For Rehab Services, Pittsburgh, PA.

Dr. Saldana: We are going to strictly stick to osteoarthritis of the base of the thumb. As the moderator, I would like to pose the first question for discussion. Do any of you use Eaton staging for your treatment?

Mr. Brach: From a therapeutic standpoint, knowing the stage may help with respect to the impairments they are experiencing at the time. In stage one or two, these patients might be more suited for therapy and/or splinting. In the later stages, therapeutic intervention may not be as successful.

Dr. Saldana: Dr. Badia?

Dr. Badia: I use it more for academic reasons and case discussion. Stage four or pantrapezial arthrosis is the only stage where I have a consistent surgical treatment. The other three stages vary greatly, depending on their true arthritis is stage, which I often determine arthroscopically.

Dr. Saldana: Dr. Adams?

Dr. Adams: I think the classification is useful in communication with your patients and with others. In general, it provides a framework for discussion and treatment. But I think it has some faults, because it doesn’t necessarily portray what you may find surgically. For example, you can have significant cartilage loss and yet it might be rated a stage two by the classification. Similarly, you may not see any cystic changes or osteophytes. So, if you apply strict criteria in using Eaton’s classification, it may not consistently apply to your patients.

Dr. Saldana: Dr. Naam?

Dr. Naam: The answer is yes and no. No, because the patient’s symptoms determine what you want to do with the patient. Regardless of stage, most patients are treated conservatively at the beginning. When I try to select a surgical treatment, then the classification comes into play. Even then, in certain stages, such as two and three, there’s really no clear definition that differentiate between surgical choices. But in stage four, the involvement of the scaphotrapezial trapezoid joint changes the available surgical options.

Dr. Saldana: Does anyone operate on an asymptomatic stage?

Dr. Naam: No.

Dr. Adams: Not in osteoarthritis.

Dr. Badia: No.

Dr. Saldana: Once you have a symptomatic patient, how long do you pursue conservative treatment? Let’s take a stage one that is very symptomatic and with 10–20 percent of subluxation.

Dr. Adams: I think several factors should be considered. The age and activity level of the patient, combined with his or her expectations are very important in deciding on surgery. I pursue conservative treatment longer in earlier stages than I do in later stages. In the later stages, I may not proceed conservatively very long if the patient has had symptoms for a long period of time. In the earlier stages, especially if it’s a younger patient with a short duration of symptoms, I would pursue conservative management for many months before I would recommend surgery, even with subluxation.

Dr. Saldana: Dr. Badia? I know you have some definite ideas about stage one.

Dr. Badia: Well, I agree with Dr. Adams, that earlier stages warrant a longer course of conservative treatment. I will determine when surgery is a good option, depending upon how long they respond to conservative treatment such as an injection. If the patient has a one-year response (which is unusual), then they warrant a repeat injection. If they respond for only several months, then I may go ahead and do an arthroscopy to determine the true stage.

Dr. Saldana: Mr. Brach, when your doctors send you a symptomatic patient, stage one, what splint do you recommend in your practice?

Mr. Brach: Typically, we fabricate a hand-based thumb spica splint.

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I USE A PALMARIS LONGUS GRAFT WHICH PASSES AROUND THE FCR AND ONE SLIP OF THE APL SEVERAL TIMES, CREATING AN OBLIGATORY INTERPOSITION.

BRIAN ADAMS, MD

needed.

Mr. Brack: A study done by Weiss, et al in the Journal of Hand Therapy in 2004, supports the use of splinting for pain relief in stage I or II first CMC OA. They also report that the use of neoprene provides greater relief of pain compared to the use of the hard plastic splints. Further evidence suggests that patients prefer the use of neoprene over the hard plastic splints.

Dr. Saldana: I use a leather hand-based thumb spica splint. But I have lots of patients tell me that that’s too hard.

Mr. Brack: The neoprene splints that we issue in our clinic are ordered through North Coast Medical. However, Sammons Preston also offers neoprene splints in various styles.

Dr. Saldana: Dr. Adams, how many injections would you give to a stage two or three symptomatic patient before you consider them failures?

Dr. Adams: If the patient responded well to the first injection, then I think there’s a good chance that they’ll respond to another injection. Whereas, if they didn’t respond well to the first injection, then the likelihood that a second injection is going to help has been low. I think it’s most useful in patients who do not have significant subluxation, and in whom I can easily palpate the joint.

Dr. Saldana: Do any of you inject and cast with a thumb spica cast for a period of three or four weeks?

Dr. Adams: I haven’t casted following an injection. I routinely recommend splinting in combination with the injection, as well as modification of activities.

Dr. Saldana: Dr. Badia?

Dr. Badia: I’ll combine injection with splinting, but I don’t want to limit their function. If the joint is severely involved, they will have a poor response, and then that will be a sign to do something a bit more aggressive.

Dr. Saldana: Dr. Naam?

Dr. Naam: No, I don’t cast them, but I always splint them with the injection.

Dr. Saldana: I’ve always casted them.

Dr. Naam: For how long?

Dr. Saldana: I usually cast them for a month, and then see what kind of a response they have. I’ve found that about 30 percent of people will not come back for a repeat injection—it may be my cast? No, they’d come back and they’d say they’re better.

Let’s address the surgical procedure for stage one arthritis.

Dr. Badia: In stage one, x-rays don’t tell you much. Once you put in an arthroscopic, you’re going to see if there’s any cartilage loss. Typically, in arthroscopic stage two, there is focal loss of cartilage, usually in a central to dorsal part of the trapeziun, and in the deep part of the metacarpal at the insertion of the volar oblique ligament. Once you see cartilage loss, I think you have to combine arthroscopy with some type of joint-modifying procedure. In those cases, I’ve been combining arthroscopy with an osteotomy. If there is a minimal cartilage loss and a lot of synovitis and capsular laxity, then I do a debridement, perhaps a thermal shrinkage. And then I will cast them for a month.

Dr. Saldana: Dr. Adams?

Dr. Adams: I rarely operate on a stage one as I just don’t make that diagnosis very often. I’m probably under-diagnosing patients at this early stage. But if I were to surgically treat this patient, I think arthroscopic evaluation is helpful to evaluate the cartilage. I think a synovectomy in some of these patients can be helpful. Following arthroscopy I would cast the patient for an extended period of time in the best reduced position. I have not been terribly satisfied with the long-term results of ligament reconstruction. There are some patients that respond well, but others don’t respond well at all. So, my results haven’t been as good as reported by Eaton.

Dr. Saldana: Dr. Naam?

Dr. Naam: For patients in stage one who are not responsive to conservative treatment, I recommend arthroscopy of the trapeziometacarpal joint. After evaluating the articular surface, I do not jump into an osteotomy even if there are early degenerative changes. I would just do a capsular shrinkage after debriding the joint. Post operatively, I cast the patient for a month. I haven’t done any metacarpal osteotomies, and I think it’s probably an excellent idea.

Dr. Badia: Dr. Saldana, can I add something? Dr. Adams mentioned that we don’t see the stage one patients early enough. If we catch
them in an earlier stage, we might be able to do enough joint modification to arrest or slow down the process. So, the real problem is that we do not have the chance to evaluate our stage one treatments because we don’t see enough of those patients.

When I started doing arthroscopy on this joint a decade ago, I found that if there was any significant articular damage, that simple debridement did great for about six months to a year, and then it came back. That’s when I started adding osteotomy for that particular stage.

**Dr. Adams:** Perhaps one of the reasons my patients haven’t done well with ligament reconstruction is because they weren’t truly a stage one. Standard radiographs don’t tell the whole story. Some patients might well have been a late stage two, and our surgical treatment may actually have increased the stresses on the joint rather than decrease the stresses. I think it’s difficult to accurately make the diagnosis at stage one.

**Dr. Saldana:** I agree. I was doing mainly ligament reconstructions until arthroscopy came onto the scene. Now, if I see more than 30 percent subluxation or more in what looks like a stage one, then the key is to put a scope in and make sure it’s not a stage two. With subluxation of that nature with no cartilage damage, I have not done the shrinkage. I go ahead and do an Eaton. I then immobilize them in a thumb spica cast for six weeks. That helps. But I had a lot of bad results. But I think that in retrospect, I thought they were stage ones. And like you said, Dr. Adams, they were probably a higher stage.

**Dr. Naam:** Has anyone tried the Zancolli procedure, where you take the abnormal branches of the abductor pollicis longus?

**Dr. Saldana:** Yes, I have tried it, but not for stage one.

**Dr. Badia:** I’ve done it on a few early stages, but not enough to be able to say I have any data on it. I’ve discussed it with Zancolli at length, and he has the interesting idea that certain people have this aberrant slip, and that that is one of the major causes of this condition.

**Dr. Saldana:** Well, it’s not certain people. When I was in the Navy, I found that a majority of people were symptomatic after a first dorsal compartment release. And then I thought about the quadriga effect in the flexor tendons. Now, when I do a first dorsal compartment release, I leave one tendon – the main abductor, the most radial one – and I take all the volar ones and throw them away. But I’m not doing it for basal joint arthritis.

**Dr. Naam:** Dr. Badia?

**Dr. Badia:** I’ve only done a few Zancolli procedures. I use it in more advanced cases when I need to take a tendon slip for an interposition. If they don’t have a palmaris, I’ll take the aberrant slip of the APL, which Zancolli describes as being the most volar one that inserts on the thenar muscles.

**Dr. Saldana:** That’s interesting. Dr. Adams?

**Dr. Adams:** I have not used the Zancolli procedure.

**Dr. Saldana:** Let’s go to the next two stages, stage two and three. Again, conservative treatment for those two stages – any different than stage one for you, Dr. Badia?

**Dr. Badia:** If it’s a stage three, I try conservative treatment a little longer, only because I don’t feel the corticosteroids are as detrimental. You already have early marginal osteophytes, a lot of joint narrowing. In medium stage two, I’m concerned that I’ll make them worse doing multiple injections. So, I’ll try one, maybe two, if they have a good response. But in most of these patients, I will try to go in earlier and try to do something to slow down the process. In stage three, I gauge it simply upon their response to injection and splinting.

**Dr. Saldana:** Mr. Brach, do you have any special tricks for stage two or stage three?

**Mr. Brach:** Depending on the degree of subluxation dorsally, you can try to reduce the subluxation through the use of splinting. Judy Colditz has developed a splint that will assist in the reduction of the metacarpal head. But myself, no, I don’t usually deviate too much from what I’ve stated previously.

**Dr. Saldana:** Dr. Adams, what is your treatment for those two stages?

**Dr. Adams:** In general, I will proceed longer with conservative management in stage two. I recommend splinting, intermittent injections and modification of activities. As they proceed towards stage three, my treatment is quite different. A true stage three with significant osteophytes, loss of cartilage space, subluxation and stiffness is identical to a stage four. And therefore, I may proceed much earlier to surgical treatment.

**Dr. Saldana:** It’s interesting to listen to both of you, because you and Dr. Badia have opposite views. How about you, Dr. Naam? What do you do for stage two and stage three?

**Dr. Naam:** In general I don’t see that much of a difference between stages two and three with respect to response to conservative treatment. But I am extremely conservative. Only, a small percentage of my patients go to surgery. I tell the patient that surgery is a good procedure, but it takes a long time to recover. So, I treat them for a relatively long period of time as long as they are making some progress. If the patient comes back after two or three years, I think it’s time to go in. I can operate whether they are making some progress or not.
three injections and is still very symptomatic, then I would consider surgical intervention.

Dr. Saldana: My treatment doesn’t change much between stages two and three. Also, I tell patients that I will only inject them two times in a year. I put a cast on them. I expect that if they’re going to respond, they’re going to respond. They’re not going to be coming back for a second or third injection within a year. If it goes to be more than two injections a year, then I proceed to do a surgical treatment. Dr. Badia, what do you do surgically for stage two?

Dr. Badia: Again, it will depend on how much cartilage injury exists. I have been using osteotomy a lot. The original paper by Wilson, later supported by Tomaino, showed that the results are quite good. I don’t think it’s just the mechanical effect, as you’re changing the vector point of contact. But I think that there is a biologic effect that the osteotomy causes a hyperemia, and may actually be beneficial to the joint. When I’ve looked at these osteotomies several years later, the metacarpal base remains well centralized on the trapezium. I think you’ve really done something to modify the joint.

Dr. Saldana: Dr. Adams?

Dr. Adams: I agree that osteotomies may be beneficial in very selected patients who have mild subluxation. I believe it does create a hyperemia that helps treat synovitis, similar to that seen with Kienbock’s disease. But in general, I am not aggressive with a stage one or an early stage two.

Dr. Saldana: How about you, Dr. Naam?

Dr. Naam: I think after listening to you all, I think I will have to do more osteotomies. But what I have been doing for stage two, is to arthroscope them. Some patients
may have significant long-term improvement. If the patient is still symptomatic, I would consider doing the same surgical procedures as for stages three and four.

Dr. Adams: I have not had a significant experience with metacarpal osteotomies, perhaps because I just don’t see many patients that are symptomatic enough to warrant an operation. When I do see a patient with early disease, I may discuss an osteotomy, but since I don’t have enough evidence to support that the operation changes the natural history of the condition, most of the patients are willing to live with their condition.

Dr. Saldana: For stage two that has failed conservative treatment and is still symptomatic, I do a modified Imbriglia, which is a hemitrapezectomy, a distal trapezectomy, and then interpose the capsule that is there. But I find that if the joint is subluxed, there’s not much capsule. So, I take those aberrant abductor pollicis longus slips and use them. Make sure to look at the scapho-trapezial joint to make sure that it’s not a stage four, because sometimes you’ll be fooled. Even in a stage two, there can be arthritis that you miss radiologically. Now, I also use the little thin 1.9 scopes.

Dr. Badia: That’s what I use. I started with a 2.7, and now I use a 1.9. The important point is that you’ve got to put that scope in your web space and lay your fingers on the dorsal aspect of the patient’s hand, so you can really maneuver it. If not, it’s going to be tiring.

In terms of the Imbriglia procedure, the arthroscopy allows me to see the cartilage loss. If it’s more advanced—which I would then call an arthroscopic stage three—then you can go and do something similar to what you mentioned. But if the cartilage loss is minimal, then the osteotomy simply has the advantage of not burning any bridges. You haven’t resected any trapezium and it’s not a big operation. You gentlemen mentioned putting them in a cast for a month. You’re doing the same thing with an osteotomy. You’ve simply made a small incision to take out a wedge.

Dr. Saldana: Well, I’m glad you’re saying that, because I don’t think I’ve ever done a metacarpal osteotomy for a stage two. But maybe I should.

Dr. Badia: Early on I was doing osteotomies on stages that were perhaps a little more advanced, and I don’t think those did nearly as well. But if the cartilage loss is not that extensive, then, anecdotally, I’ve revised very few of them.

Dr. Naam: Dr. Badia, do you perform a metacarpal osteotomy for stage three arthritis?

Dr. Badia: An Eaton stage three can be what I would call either an arthroscopic stage two or three. If it is a stage three, that implies that there’s extensive loss of cartilage on the trapezium. Then I either do some type of arthroscopic interposition, or, depending upon the shape of the trapezium and other factors, I may convert to an open procedure.

Dr. Saldana: Well, then, once you’ve done a procedure, what kind of therapy do you prescribe for your patients after surgery for a stage two arthritis? Do you send them to therapy, Dr. Adams?

Dr. Adams: In the few patients who I offer surgery for a stage two, I would proceed very, very slowly after surgery. My therapy recommendations are for gentle range of motion, and avoid stress for a minimum of four months.

Dr. Saldana: Mr. Brach, how soon do people send patients to you after a stage two surgical procedure?

Mr. Brach: The patients are sent over to therapy about 2 weeks after surgery for a post operative splint, usually a forearm-based thumb spica. It is a very slow, methodical timeframe as far as getting back to their activity level.

Dr. Saldana: Let’s go to stage three. Dr. Badia, how do you know it’s stage three and not stage four?

Dr. Badia: Radiographically, I simply look at the STT joint. I will tell you that, if the STT joint is not severely involved on the radiograph, and they’re not symptomatic with direct pressure on physical exam over that area, then I often treat them like a stage three. And that will depend on many factors, as we’ve mentioned before. Their age, activity level, and expectations are all factors. With older patients, at this point I will often go and do a total joint arthroplasty of some type. That is simply because I like the rapid recovery that they get. They don’t have to invest as much time in therapy.

Dr. Saldana: You’re not talking about the Burton-Pellegrini?

Dr. Badia: No.

Dr. Saldana: Total joints.

Dr. Badia: Total joint, exactly. The only time I do a complete excisional arthroplasty would really be in a true stage four, symptomatic stage four, or a stage three where the trapezium is very flat and very deformed. And at that point, I think the excision of it and your choice of ligament reconstruction is warranted.

Dr. Saldana: Now, Dr. Adams, what are you doing for a stage three?

Dr. Adams: Treatment depends primarily on the age and activity level of the patient. In most of my patients who are elderly, I perform a complete trapeziectomy and a ligament reconstruction with an interposition. In a select group of patients in the past, I tried implant arthroplasty. But there was radiographic deterioration with time. Some of the deterioration was quite worrisome. Thus, I rarely recommended before. Their age, activity level, and expectations are all factors. With older patients, at this point I will often go and do a total joint arthroplasty of some type. That is simply because I like the rapid recovery that they get. They don’t have to invest as much time in therapy.

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mend the implants currently available.

Dr. Saldana: Dr. Naam?

Dr. Naam: Well, I think it’s very important to be sure that the scaphotrapezial trapezoid joint is not involved. X-rays are not always very accurate in telling you whether the STT joint is involved or not. So, practically speaking, sometimes the differentiation between stages three and four may happen only at the time of surgery.

But in general, I treat stage three exactly like stage four, with one exception. I will do an arthrodesis of the trapeziometacarpal joint in young males who are involved in heavy manual work provided they don’t have STT involvement. I tell the patients before surgery that if there is any involvement of the STT joint, then I will go ahead and do a ligament reconstruction and tendon interposition arthroplasty. If the STT joint is pristine and clean, then we can go ahead with the arthrodesis. I prefer to do a complete trapezial excision with ligament reconstruction using the FCR tendon.

Dr. Saldana: But how are you assessing the scaphotrapezial trapezoid joint? Visually at the time of surgery? Or are you sticking a scope in there?

Dr. Naam: No. I do it visually. You are already committing yourself to do an open procedure, either arthrodesis or arthroplasty. I do not do hemiresection of the trapezium.

I honestly have not seen a significant advantage of removing only half of the trapezium. But if I am thinking of doing an arthrodesis, I tell the patient I’m going to inspect the scaphotrapezial trapezoid joint visually. And if the joint is healthy, I will proceed with the arthrodesis. Otherwise, I will make it an LRTI.

Dr. Badia: I’d like to echo that I think that the young laborer is an excellent candidate for an arthrodesis. But there is another option available now in the younger patient. When I see a stage three, where there is some subluxation in a fairly active, younger person, I have been using the Artelon spacer. It allows us to do an interposition arthroplasty with minimal resection. But it also has the added advantage of stabilizing the joint, particularly in those patients where you see some subluxation. You have an advantage of both providing interposition and providing stability to the joint with a procedure that is minimally invasive and doesn’t burn significant bridges.

Dr. Naam: And what do you use, Dr. Badia?

Dr. Saldana: The Artelon.

Dr. Badia: It’s a polyurethane urea material (correct?) that you insert between the metacarpal and the trapezium.

Dr. Naam: I have just removed two of them the last year.

Dr. Badia: Is that right?

Dr. Naam: Both were done somewhere else. But failure could be related to technique. I am not aware of any long-term results. Failure of such procedures could be related to technical details and the expertise of the surgeon, or it could be related to an inherent problem in the design. You almost have to wait to see long-term results before you really commit yourself to doing them.

Dr. Saldana: It’s new in the United States, but it’s well published in the European literature.

Dr. Naam: Swedish.

Dr. Saldana: Well, when I saw the implant, the thing that discouraged me is that the interposition is just a little tongue that doesn’t even cover half of the trapezium. In other words, you do a distal trapezeectomy, but then you put in this little piece that is not long enough or wide enough. That’s why I have not been using it. Instead, ever since that little scope came out, I’ve been using it. But with the scope, once you’re open and you’re looking at that scaphotrapezial trapezoid, it’s very easy to see whether there’s any involvement or not. I still do the Imbriglia procedure for stage three, thinking that leaving at least half to two-thirds of the trapezium gives more support. I also do it on young people, because I feel that leaving a piece of bone there to support the metacarpal is a good thing, provided that the more proximal joint is not involved.

What are your preferences, then, for Eaton stage four?

Dr. Adams: In the vast majority of my patients, it will be a trapezium resection, soft tissue interposition, with ligament reconstruction. For more than 10 years I have used a modification of the Weilby procedure, which allows me to rehab my patients very rapidly, beginning at 2 weeks in a splint.

Dr. Saldana: Can you describe very briefly the hammock procedure? That Weilby?

Dr. Adams: I have modified it, but Weilby should be given the credit. I use a palmaris longus graft which passes around the FCR and one slip of the APL several times. Typically, you can pass it around the two tendons four times. It creates an obligatory interposition, as well as a ligament reconstruction. It provides a very solid support, reduces the metacarpal, and it creates a broad interposition.

Dr. Saldana: Dr. Naam, what do you do?

Dr. Naam: I do the simple, straightforward ligament reconstruction and tendon interposition arthro-
plasty. I still use half of the flexor carpi radialis. The classic description. I pin the first metacarpal to the second metacarpal and I leave the pin for five weeks. I put the patient in a splint for two weeks and then a cast for three weeks. I take the cast off and take the pin out at five weeks, and then start moving them gradually and give them an orthoplast splint to use intermittently. I tell the patients from the beginning that this is a long process. It takes a while before patients achieve maximum recovery, either strength or endurance.

Dr. Saldana: What is a long while?

Dr. Naam: I tell them it takes about six months. Usually they are happy by three months, but they are still not back to normal. I tell them about six months so the patients will not be disappointed when, at three months, they are still having weakness or some discomfort. It takes a while. And in this particular operation, I found from my experience that the thumb function improves by time.

Dr. Saldana: Dr. Badia, what do you do?

Dr. Badia: I do a modification of Thompson, a suspensionplasty, using a slip of the APL tendon.

Dr. Saldana: Now, I’d like to ask about complications. I know that there’s a common complication that perhaps we ignore. When you have scaphotrapezial trapezoid arthritis, and you take out the trapezium, what do you do for the scaphotrapezoid arthritis? Dr. Adams? Do you do any nibbling at that joint? Do you ignore it? People have described pain at that joint when left alone.

Dr. Adams: I couldn’t agree more that one of the problems I see in my patients is persistent or recurrent pain due to scaphotrapezial arthritis. It’s probably a more common phenomenon than we originally thought. The Eaton view, which I get in all of my patients, gives you a nice profile of the STT joint. If I
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see significant arthritic changes, then I will take a small amount of the proximal trapeziod away. It is typically well suspended by the capitate, and so I don’t really put much material on the space.

Dr. Saldana: How about you, Dr. Naam?

Dr. Naam: I always inspect the scaphotrapezoid joint. If I see some degenerative changes, either at the trapeziod side or the scaphoid side, I do a simple resection arthroplasty of the scaphotrapezoid joint using the rongeur. Then I put the end of the FCR tendon between the scaphoid and the trapezoid.

Dr. Naam: What do you do with the metacarpal phalangeal joint?

Dr. Saldana: That’s a very, very important point. I think in all stages, you have to inspect the metacarpal phalangeal joint. If it’s going into hyperextension, you need to correct that deformity. How about you, Dr. Adams? Do you do that?

Dr. Adams: If the MCP point is not painful, then I usually do not correct the hyperextension. I find the trapeziectomy essentially decompresses the first ray. And the hyperextension sort of self-corrects itself to a great degree.

Dr. Saldana: Dr. Badia?

Dr. Badia: In the very mild cases, I’ll occasionally pin them in slight flexion while I keep them immobilized, for treating whatever basal joint reconstruction construction I do. One of my favorite procedures is actually the very advanced Z deformity with the adduction contracture. And in those, I will do a total joint arthroplasty. I’ll release the adductor. And then I’ll do a volar plate capsulodesis with a small bone anchor. I’ve been very happy with that combination. I’ve had many people come back to have the second side done. So, in those cases I’ll do it. But I agree that in the ones that are asymptomatic and mild, I don’t think they usually need anything.

Dr. Naam: I essentially do the same. Most of the hyperextension of the MP joint improves after correcting the deformity at the CMC joint. If there is still mild residual deformity, you can just leave it alone. Sometimes I pin the joint in about 30 degrees flexion if the hyperextension deformity is relatively mild. Other than that, I would do a volar capsulodesis. I use either – Mini Miteck anchor or a pull-out wire. I haven’t done arthrodesis of the MP joint for a long time. But I think there is a role for arthrodesis if the hyperextension deformity is more than 30 degrees and is not correctable.

Dr. Saldana: When I do the Imbriglia procedure, and I have hyperextension at the metacarpal phalangeal joint, I transfer the extensor pollicis brevis under the abductor and put it into the flexor side of the extensor mechanism of the thumb, bringing the joint into flexion. That’s worked pretty well for me.

Mr. Brach, are there any things that you would like to add to the final minutes of this conversation?

Dr. Adams: What has been your experience with using splinting techniques for people with hyperextended MCPs and mild to moderate CMC disease?

Mr. Brach: I have tried to do some splinting of the MCP joint for many types of hyperextension, whether it is to protect the volar plate, or in this case reposition the thumb MCP joint. I find that I can position the joint properly in the 10 to 20 degrees or more of flexion that is required, however, I find it difficult to maintain that position with an isolated splint to that joint alone because of the forces that are transmitted to the MCP joint during phalangeal activities. I believe that it can be done. However, I haven’t had great success in doing it. I don’t know if it’s just because of

Arthrosis in the Hand

This issue of the Coding Corner will address procedures to treat arthritis in the hand and wrist. Since a previous column discussed the codes associated with treating thumb basal joint arthritis, we will not be addressing that particular code family here.

Most procedures to treat arthritic conditions in the hand relate to synovectomy, joint replacement, or arthrodesis. Synovectomy for the CMC joint is coded with 26310; synovectomy for the MCP joint or PIP joint is coded with 26135 or 26140, respectively. Note that these codes include extensor mechanism reconstruction and intrinsic releases.

The arthrodesis code family for the hand includes eleven items. Fusing the thumb “in opposition,” which ostensibly would include fusing both the thumb CMC and MCP joints, is coded with 26820 (which includes obtaining autograft). Fusing the thumb CMC joint alone is codes with 26841; code 26842 is appropriate if autograft is used. Fusion of a CMC joint that is not the thumb is coded with 26843; again, if autograft is used, a different code (26844) is appropriate.

Arthrodesis of an MCP joint is coded with 26850; if autograft is used 26852 is the correct code. Fusion of and interphalangeal joint, either PIP or DIP, is coded with 26860. If autograft is used, the code becomes 26862. If several interphalangeal joints are fused, each additional joint (after the first one) is coded with 26861; if autograft is used for each subsequent joint, then 26863 is appropriate.

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Wrist arthritis procedures include both flexor and extensor tenosynovectomies. Code 25115 corresponds to radial flexor tenosynovectomy and code 25116 corresponds to extensor tenosynovectomy. Excision of the distal ulna, a common adjunct in treating rheumatoid arthritis, is coded with 25240. Removing a single bone from the wrist, as in scaphoid excision, is coded with 25210. Proximal row carpectomy corresponds to 25215, and radial styloidectomy is coded with 25230.

A total wrist fusion corresponds to code 25800; with local sliding graft, the code becomes 25805, and if iliac or other autograft is used, then the correct code is 25810. A limited wrist fusion without bone graft is coded with 25820. If autograft is used for a limited wrist fusion, the appropriate code becomes 25825. The Sauve-Kapandji procedure, which involves fusion of the distal radioulnar joint (with or without bone graft) is coded with 25830.

A 26-year-old male presents for excision of a ganglion on his dorsal wrist. He had the lesion removed seven years ago, but it returned last year. He also note that he sustained a metal splinter in his index finger on the same hand six months ago and continues to have pain there. You decide to proceed with removal of the ganglion and attempted foreign body removal of the index finger. Upon exploration, the splinter is found to rest in the insertion of the profundus tendon.

Solution:
Code 25112
20525-51

You Code It
my technique, or just the type of splint I’m trying to use. When properly splinted, it should provide some benefit to the patient to offer more support and function during prehension activities.

**Dr. Saldana:** Gentlemen, any other complications from your surgery that you’ve seen that should be mentioned?

**Dr. Naam:** I think I would mention the partial or total injury to branches of the superficial radial nerve.

**Dr. Saldana:** Well, you’re not supposed to have that complication.

**Dr. Naam:** I know. But branches of the superficial radial nerve should be identified and protected by a vessel loup. They should be re-inspected before closure. Sometimes patients may have some degree of numbness for a while. But at least you know that the nerve has not been damaged. If the nerve is injured, it should be repaired.

**Dr. Adams:** I think the most common complication is failure to adequately relieve all discomfort and restore an adequate pinch. I think the overall complication rate is not trivial, but neither is it high, so we continue to do this operation routinely.

**Dr. Badia:** I’m glad you mentioned that, because it’s one of the reasons I really try to avoid the resection arthroplasty, because I just think there’s no bailout at that point. And I’d love to hear what the panelists do in the occasions where patients do have a persistent amount of discomfort and you’ve already done some type of resectional arthroplasty. And what bailout do you have at that point?

**Dr. Saldana:** OK. Start with – let’s say, Dr. Adams, you have a – you’ve done a resection arthroplasty with a your Weilby weave. And, well, that’s very unlikely to collapse. Let’s say you did a Burton-Pellegrini and it collapses. The thumb is collapsed and it’s painful and it’s almost touching the scaphoid when you take an x-ray. What do you do for that patient?

**Dr. Adams:** The most likely procedure that I will do is a very aggressive soft tissue interposition. That may require going to a more distant place to find an adequate tissue graft.

**Dr. Saldana:** Dr. Naam?

**Dr. Naam:** Well, the most important thing is we have to analyze what’s the cause of the patient’s problem. And there are several. It could be the scaphotrapezoid joint. Sometimes it’s a small osteophyte interposed between the first and second metacarpal. This osteophyte should be removed during surgery. Sometimes there is impingement between the base of the first metacarpal against the scaphoid. I think you have to analyze why the patient is not comfortable. If the scaphotrapezoid joint is OK, and there are no other osteophytes, I totally agree with Dr. Adams, that sometimes you need to go back and redo the whole thing. Just be sure that the first metacarpal is positioned at the level of the second metacarpal.

You may have to repeat the interposition and the suspension. If part of the FCR is still available, then the reconstruction can be redone using the remaining FCR tendon slip. Otherwise, another method of suspension and interposition can be performed. A bone
THE MIDDLE FLEXOR RETRACED TENDON: PRACTICAL TIPS FROM THE CLINICAL EXPERIENCE

Anchor could be used at the base of second metacarpal to anchor a tendon graft that could be used in the reconstruction in the absence of FCR tendon. But I think the most important thing in my opinion is analyzing the cause of the patient’s symptoms.

Dr. Saldana: Dr. Badia, what do you do?

Dr. Badia: Well, since I don’t do that many excisional arthroplasties any more, I don’t tend to see that problem. I occasionally will see them when they’ve come from elsewhere. And then I will do a very aggressive interposition. I’ll try to do some type of suspension of the metacarpal and create some type of a sling at that point.

Dr. Saldana: I use the extensor carpi radialis longus. Not all of it; half of it. And then go around the metacarpal and back to the second metacarpal and suspend it like a little sling. Done that several times, and it’s worked.

I want to thank all the participants – Dr. Adams, Dr. Badia, Dr. Naam and Mr. Brach. Good night.

SECRETARY A. LEE OSTERMAN, MD

Dr. A. Lee Osterman is the current secretary of the AAHS and Program Director for the 2007 Annual Meeting at the Westin Rio Mar Beach in Puerto Rico. He has been a member of the organization for over 20 years. Joe Danyo, the first President, suggested to him that the AAHS was an organization that met all the goals of a hand surgery career: enthusiasm for and excellence in education, exposure to new ideas, and most importantly, the camaraderie of like-minded individuals. “The annual meeting in January has become a time to renew my hand surgery spirit and to relax in a friendly atmosphere.”

Lee grew up in West Virginia before attending Yale College where he majored in photography. After graduation, he traveled on a Guggenheim fellowship photographing original stained glass in Europe. Subsequent to that, he traveled to Tanzania where he photographed doctors working with native tribespeople on an UNESCO project that eventually became a book, Jungle Doctor Panorama. That experience, combined with a family medical background, set him on a course to medical school.

He spent the next 10 years of training at the University of Pennsylvania where he did his medical school, orthopaedic residency and hand fellowship with Dr. F. William Bora. It was in his first few weeks in the anatomy lab that his realized his future passion. “The most human part of a cadaver is its hand.” The only time away was an internship at Mt. Sinai Medical School in New York City where he met his future wife, Elissa Topol, and a microvascular fellowship with Dr. Jim Urbaniak at Duke University.

He returned to Penn where he practiced and taught until 1993. Then the two Philadelphia hand groups from Penn and Thomas Jefferson merged to form The Philadelphia Hand Center, a practice that encompasses the full gamut of shoulder to hand problems, including congenital reconstruction, microsurgery, trauma and adult reconstruction. He is a Professor of Hand and Orthopaedic Surgery at Thomas Jefferson University. He divides his time between teaching (not only locally but around the around), writing (he has edited one of the most popular hand surgery text, Rehabilitation of the Hand ), and an active clinical practice.

He finds enjoyment in the mountains of Colorado where he spends part of the summer biking, hiking, and absorbing good music in the natural beauty of the area. His oldest daughter, Meredith, is a 3rd year medical student. His middle daughter, Alexis, lives in Aspen and works for Aspen Magazine. His youngest, Zoe, is finishing her junior year at Choate Rosemary Hall.

He has been active in the AAHS governance since 1998, having headed a number of committees and programs. He has been on the board since 2000. In those years he has seen the AAHS become a major force in hand surgery. “The quality of its educational programs, the attractiveness to new members and the organizational stability have continue to mature.” He sees more exciting developments with the initiation of a new journal, HAND, and website interactivity.

He concluded that “being a member of AAHS has been one of the most rewarding aspects of my career.”
treated to a boat ride of the city’s inner harbor. Dr. Vargas now had Juli Howell, Lynne Feehan and myself cornered. He again presented his idea of a physician-therapist team who would travel to other countries to exchange hand surgery and rehabilitation concepts, using the local resources. Realizing that this would become an annual, unrelenting plea, a proposal was submitted to the AAHS Board of Directors to fund such a request. Dr. Beckenbaugh, 1992 President, approved a task force to submit a formal request for this initiative. The original task force included: Maureen Hardy PT MS, Chair, Lynne Feehan MsPT, Bob Demuth MD, Wyndell Merritt MD, Bob Russell MD, Randy Sherman MD, and Bob Schenck MD, with Dr. Miguel Vargas as a consultant. This group exchanged phone calls and letters for one year (prior to e-mail), and a breakfast meeting was scheduled at the next annual meeting in Cancun. Our goal was to finalize the proposal for submission and decide on a name for this

continued from page 1

“The Vargas award was a life altering and life enhancing experience. My growth as a therapist and person is undeniably due to the challenges presented to me during this experience.”

—Sharon Dest

2001: In Uganda, hand surgeon Dr. Scott Kozin was both partner and mentor.

2004: Sharon Dest, PT, CHT, at right, with patient at therapy clinic.

1996: Lynne M. Feehan, MSc(PT) reporting on her experiences in Thailand at the Hand Therapists Seminar.


2002: A sweet 13-year-old orphaned girl, whose dominant hand was twisted radially at the wrist, is treated by Gail Groth, MHS, OTR/L, CHT (right) and a Ugandan physical therapist.
As we sat in the open-air restaurant waiting for Dr. Vargas to join us, the news arrived that Dr. Vargas had died suddenly, just prior to the meeting. This sobering news fortified our resolve, and we all knew what the award would be named.

The 1994 AAHS Board of Directors, under Dr. Robert Russell, President, accepted and funded the proposal which was named The AAHS Vargas International Hand Therapy Teaching Award. In 1996, the first award was granted. The recipient, Lynne Feehan, and Dr. Somprasong Songcharoen, who coordinated the academic and clinical teaching venues, reported on their experience at the following Annual Meeting. These moving presentations have become a highlight for our membership. We are proud of all the professionals who took Mr. Twain’s advice to sail away, explore and share their talents.

“Being awarded the Vargas further reinforced my commitment to continue this work in Guatemala, where there is now an active and growing hand therapy association.”

—Lynn Bassini

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"The opportunity to share our expertise as a therapist-physician team was extremely valuable to our colleagues in Cairo."

—Katherine Schofield

"In retrospect, I went to teach, but I learned far more than I taught. The Kenyan people, who hurry less and enjoy the process of living more, seem to understand that more is not always better."

—Colette Jewell

“I still continue to be in contact with the therapists I met on my trip. Two therapists from Thailand came to Canada and USA for three months of training. I made a follow-up trip back to this country 3 years later for a course attended by over 100 therapists.”

—Lynne Feehan

“The education seminars were well received and appreciated as there is little time or opportunity to leave the Navajo nation. As the AAHS mission is grounded in education, future support through online or video conferencing may be possible.”

—Sue Michlovitz

“The Lithuanian medical team consisted of 2 surgeons, a hand resident, 5 nurses and for the first time, a hand therapist. At the end, I felt like I had gained more than I’d given, which I guess is how this wonderful exchange works.”

—Karen Henehan

“It was an elixir for the soul to bring OTs and PTs together for training. I do believe that we helped quite a few patients along the way, and hopefully more will benefit indirectly from our teaching efforts here.”

—Gail Groth
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