The 37th annual AAHS was held at the Westin Rio Mar Golf resort and spa in Puerto Rico was a resounding success with 305 members attending. President Ron Palmer and his wife Cathy were gracious and attentive hosts. The theme of the meeting was “Hand Treasures of the Caribbean”.

Brian Adams and Aviva Wolff opened speciality day with a program entitled “Rapid Recovery—the Fast Track” that highlighted surgical and rehabilitation techniques which foster healing and return to activity. The program covered the spectrum of care from work injuries in firefighters to getting the athlete back in the game. As a measure of its appeal, the course held the audience through the final lecture despite the gorgeous tropical weather.

Wednesday afternoon marked the Inaugural meeting of La Federación del Mano where Professor Eduardo Zancolli, III offered an historical perspective and wishes for a bright future for the fledgling organization.

The late afternoon offered bioskills courses spanning the gamut from wrist fracture to joint replacement. The participant could have his wrist, DRUJ, thumb CMC, and finger joints replaced after his distal radius fracture was stabilized.

The evening opening reception capped the exciting day and provided the conviviality of rum, conversation, and a chance to renew old friendships.

Thursday began early with ICL’s that each attracted a crowd. New topics included methods of journal article evaluation and emerging concepts in the treatment of tenonopathies. Dr Palmer officially opened the meeting after which Elvin Zook, editor, introduced the society’s official new journal, HAND.

Amy Ladd, Mary Marzke, an anthropology professor, and neurologist Frank Wilson, author of The Hand: How Its Use Shapes the Brain, Language, and Human Culture teed off the generation.

Out-going President Ron Palmer, MD (at left) receives Presidential plaque from in-coming President N. Bradley Meland, MD. Between sessions, the sands outside the Weston Rio Mar Beach Resort beckoned.
"Whose man is he?"

At the Democratic National Convention in 2000, Al Gore famously announced "I am my own man," thus declaring his independence from the policies (and, one assumes, some of the behaviors) of his 1992 and 1996 running mate, Bill Clinton. I don’t recall being particularly impressed by the declaration; after all, the policies were, in general, nothing to be ashamed of, most people don’t think that adultery (depending on what the meaning of “adultery” is) is contagious, and it is pretty sad when a 50-something feels the need to make such a declaration in the first place.

Nevertheless, I was reminded of this comment recently, in the context of a similar reference to me. I had been invited to speak at a national specialty society meeting in Europe, and queried whether my way would be paid by the society. There followed a hurried, sotto voce discussion in the native language, of which I understood enough to catch a phrase, which I translated as “whose man is he?” I wasn’t exactly sure what they meant, but eventually I was told that the society would pay my way. I returned some months later, gave my talk, and in general enjoyed my visit. I subsequently asked a friend, though, what had been meant by the odd turn of phrase. Had I misinterpreted? No, I was told, what they wanted to know was which companies I had financial relationships with, that could be depended on to buy my airplane tickets. As it developed, I was no one’s “man”, and so the society needed to do a bit of searching to identify a funding source to cover my expenses.

I doubt that anyone who has a financial relationship with a commercial enterprise, whether that be as a consultant, inventor, or otherwise, considers themselves literally the company’s “man”, but I find the use of term telling. The fact that it was used so casually suggests that, even among professionals who deal with such relationships daily, the relationship is considered to be more than a dry financial transaction. The company has not just purchased access to the clinician’s knowledge, expertise, or intellectual property; it has in a sense acquired the clinician’s reputation as well. And the clinician has acquired a bit of the company’s reputation in turn. But in polite society we don’t suggest that the clinician is the company’s “man”. Instead, we use a legal term: conflict of interest.

Today we hear a lot about conflicts of interest. My institution’s definition is: “a divergence between an individual’s or an institution’s private interests and their professional obligations either to a patient or to society such that an independent observer might reasonably question clinical practice, research, investment, leadership or purchasing actions taken by the individual or the institution that may have been influenced by consideration of significant financial conflict of interest. Conflict of interest depends on the situation, and not on the character or actions of an individual.”

Note that the determination of the conflict is not up to the parties involved in the relationship but rather to a reasonable “independent observer”. If it looks to a disinterested third party like you have a conflict, you do. And so it is incumbent upon us to disclose any potential conflicts, which is to say any situation that might arouse the concern of a third party. If a reasonable person thinks you are someone’s “man” or “woman”, then so you are. If you suspect that a reasonable person might think so, then you have a duty to disclose the relationship. Mayo’s policy mentions not only research, which only some investigators may do, and investment, leadership and purchasing decisions, which officers of an organization may be required to make, but also a duty to disclose to our patients, if we have a “private interest”, such as a royalty, investment or consulting relationship, that a reasonable person might suspect would affect clinical decision making. Some organizations (and Mayo Clinic is one of them) go so far as to refuse free drug samples, considering such gifts to be a particularly pernicious, and often subliminal, form of influence on decision making. Research has shown that even small gifts, whether of free samples, meals or other such items, are sufficient to affect physician decision making, albeit in subtle and subconscious ways.

Physicians who receive such gifts...
are more likely to prescribe drugs manufactured by the donor, or to request that such drugs be added to hospital formularies. Thus the recent effort to replace free samples with a system of vouchers for low income patients, and to be sure that all physician-industry relationships are contractual, with specific deliverables in exchange for, and proportionate to, the benefits being received.

Of course, contractual relationships do not eliminate conflicts; they merely specify the details of the relationship more explicitly. Such relationships must still be disclosed, reviewed by an impartial third party (such as an institutional conflict of interest board) and managed in some way. Mayo requires management when a conflict is substantial; usually this means income of more than $10,000 per year from royalties or consulting with an individual commercial entity. Depending on the specific nature of the conflict, management might include disclosure alone, disclosure combined with divestiture of the private interest creating the conflict, recusal from the professional activity being conflicted, or some modification of the activity to accommodate continued possession of the private interest, including in some cases documentation of supervision by an unconflicted colleague, or even a supervisory committee, of decisions to use products involved in the conflict.

Clearly, someone whose clinical practice must be restricted in some way as a result of a conflict of interest cannot easily answer the question “whose ‘man’ is he?” William J. Mayo once said “Commercialism in medicine never leads to true satisfaction, and to maintain our self-respect is more precious than gold.” I like that. So much simpler than review boards and oversight committees. So much better than, like Al Gore, to ask for a do-over at age 50. Whose ‘man’ are you?

**Continuing On Track**

Greetings to all of the members of the American Association for Hand Surgery. What a wonderful meeting we just finished at the Westin Rio Mar in Puerto Rico.

I’d like to take the opportunity to thank our past president, Dr. Ron Palmer, on a very excellent and entertaining meeting. Thanks should also go to Dr. Osterman and Dr. Orbay, for the excellent program they put forth at our annual meeting. I attended the entire hand therapy meeting on rapid recovery and would like to commend Aviva Wolf and Brian Adams on a great program.

I look forward to serving as your president this year. As mentioned by many presidents in the past, it is a humbling experience and I have already found out through weekly teleconference calls and several other urgent issues, that the hand association is run well, but there is a lot of work to be done behind the scenes. We are happy to do it. I have a great group helping me and I’m completely honored to serve in this capacity.

I would like to welcome the new members to our Board of Directors, the new Directors at Large and Affiliate Directors (see box below). I look forward to working with all of these new members as well as the previously elected members whom you all know.

Already, work has started on the 2008 annual meeting in Beverly Hills. Dr. Mike Neumeister, Dr. Craig Johnson and Christine Novak, PT are the program chairs. We have already had meetings and by the time this newsletter comes forth, we will have made a site visit to the hotel to finalize menus, activities, side trips and the golfing tournaments.

continued on page 4

**American Association for Hand Surgery 2007 Officers and Board**

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<td>Treasurer (1 year remaining)</td>
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<td>Nominating Committee</td>
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Hand Surgery Quarterly
Spring 2007
“No Hand Left Behind” is the theme of next year’s meeting. As I thought of this theme, it pertains to so many things the association stands for. In this coming year, I have no new agendas. We have several old agendas that we will maintain and continue to grow and thrive. That being:

- To recruit new members, both active and affiliate, so the organization can continue to grow
- To continue to support the Hand Surgery Endowment
- To support and maintain our new journal HAND, which is being excellently edited and run by Dr. Zook and if you see him, give him a big thank you for doing this. We have now had two issues published and I think the articles are great and if you have articles, please submit them to our journal.

Dr. Richard Berger just went off our board after his year as penultimate past president. I want to thank him for his incredible effort in getting La Federación of Hand Surgery organized to support our brothers and sisters in hand surgery and all of the Americas. He basically did this on his own. The organization is now up and running, free-standing and in fact planning on having their own meeting next year. We are all proud and grateful to Dick for the wonderful work he has done and we assured him that our group, the hand association, will do whatever we can to support La Federación.

We also learned this past week that Dr. Alan Freeland has stepped down as President of the Hand Surgery Endowment. Dr. Freeland has been a friend, mentor and leader. I have learned a lot from him throughout his 15 years on the board of directors. We will miss him and his leadership in the hand surgery endowment. I am incredibly grateful for all that he has done for the group, the association and the endowment and if any of you get time or run into him, please give him a thank you or send him an email. I’m sure he would appreciate it. Bill Swartz, Vice President of the Hand Surgery Endowment Board, will take over the reins of the endowment and I’m sure you will be hearing from him in the future, in regards to the direction and appropriate actions of the endowment for our membership.

Again, I want to thank everyone who participated in our meeting in Puerto Rico; all of you who attended, taught, lectured and presented papers. I especially want to thank Laura Downes Leeper and Alice Romano for their incredible work on behalf of the association, as our administrators. I look forward to an exciting year as your president and a great meeting in Beverly Hills, led by my program chairs. We will update you further in our next newsletter.

Sincerely,

N. B. Meland, MD
Introducing Editorial Manager – Submit your manuscript online.

HAND
The Official Journal of the American Association for Hand Surgery

Editor-in-Chief: Elvin G. Zook, M.D., SIU School of Medicine, Springfield, IL, USA

HAND is a peer-reviewed journal featuring articles written by clinicians worldwide, presenting current research and clinical work in the field of hand surgery. It features articles related to all aspects of hand and upper extremity surgery and the post operative care and rehabilitation of the hand.

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► Invited Book Reviews
► Letters To The Editor
► Correspondence and Brief Communications
► Tips, Suggestions, Comments
► Review Articles

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Jabaley Receives Prestigious Award

Dr. Michael E. Jabaley was chosen by the Southeastern Society of Plastic and Reconstructive Surgeons as the 2006 recipient of the prestigious Pickrell Award at the Society’s annual meeting in Sea Island, Georgia. The Pickrell Award “is presented to the person who most closely exemplifies, in his commitment to plastic surgery education, the characteristics of the late Dr. Kenneth L. Pickrell. This award is not necessarily given every year.”

Dr. Pickrell was a renowned surgeon and teacher who served for many years as the chairman of the division of Plastic Surgery at Duke University.

Dr. Jabaley has taught two generations of surgeons—in medical school, residency, and as a guest lecturer in many medical centers. His first academic position was as assistant professor of plastic surgery at the Johns Hopkins School of Medicine. Then from 1971 to 1979 he was Professor and Chairman of the Division of Plastic Surgery at the University of Mississippi Medical Center. Since 1979 he has been in the private practice of plastic and reconstructive surgery in Jackson. He has continued to teach, serving as Clinical Professor of Plastic and Orthopaedic Surgery at UMC for the last 27 years. He has been a visiting professor at medical schools around the world, including UCLA, Harvard, Columbia, Vanderbilt, Walter Reed, LSU, Stanford, Emory, as well as in Sweden, Switzerland, South Africa, Thailand, and Japan. He has written dozens of medical papers and book chapters, and has co-authored a book on Hand Surgery.

Dr. Jabaley, who received his bachelor’s degree from Vanderbilt University and his medical degree from Johns Hopkins University Medical School in Baltimore, did his surgical training at Johns Hopkins and at the Massachusetts General Hospital in Boston. He then spent 1969-70 in Vietnam as a major in the U.S. Army. A recipient of the Bronze Star, he operated on both Vietnamese and American soldiers as well as on Vietnamese children. He is board certified in general surgery, plastic surgery, and hand surgery and has served as President of the American Association of Plastic Surgeons, the American Society for Surgery of the Hand, the Sunderland Society, and the Mississippi chapter of the American College of Surgery. He was also on the American Board of Plastic Surgery for six years, serving as Vice-chairman in his last year. He is a past recipient of the AAHS “Clinician of the Year” award. Dr. Jabaley is married to Mary Jabaley and has five children. He practices with Plastic and Hand Surgery Associates in Flowood, Mississippi.

AAHS 2007 Award Winners

Research Grants

1st Place  “An Investigation of Modality-specific Nerve Regeneration”  Principal Investigator: Thomas Tung, MD, Washington University in St. Louis, St. Louis, MO

2nd Place  “Langerhans Cell Trafficking in Composite Tissue Allotransplantation”  Principal Investigator: Mario G. Solari, MD, University of Pittsburgh, Pittsburgh, PA

3rd Place  “Initial Antibiotic Strategy for Upper Extremity Infections in the Era of Increasing Prevalence of MRSA”  Principal Investigator: Steven J. McCabe, MD, University of Louisville, Louisville, KY

Resident/Fellow Papers

Best Clinical Paper Award  Martin R. LeBlanc, BSc, MD, Dalhousie University, Plastic Surgery Program, Halifax, NS, Canada  “A Detailed Cost and Efficiency Analysis of Performing Carpal Tunnel Surgery in the Main Operating Room versus the Ambulatory Setting”

Best Research Paper Award  Colin Riordan, MB, BCh, MRCS, Dublin, Ireland  “Biomechanical Analysis of a New Ultrasound Welded Knotless Tendon Repair”

Vargas International Hand Therapy Teaching Award  Roberta Finley Morris, OTR/L, CHT, Destination: Sofia, Bulgaria, accompanied by Jaiyoung Ryu, MD, FACS
President N. Bradley Meland, MD

N. Bradley Meland, MD joined the American Association for Hand Surgery at the annual meeting in 1988. Since that time, he has attended all of the annual meetings, except two because of family emergencies. He has been fortunate to be involved in the Board of Directors or on the committee structure since 1990.

Dr. Meland graduated from medical school at the University of North Dakota in 1979 and did five years of surgery residency at Saginaw Cooperative Hospitals in Saginaw, MI, an affiliate of Michigan State University. Following his five year general surgery training, he trained at the Mayo Clinic in Rochester, MN in plastic surgery from 1984-1986. He then did a six months micro vascular orthopedic fellowship at the Mayo Clinic in Rochester, MN under the guidance of Dr. Michael Wood and Dr. William Cooney. Following that, he did a six month hand fellowship with Dr. Bob Belsoe, Dr. Tom Greene, Dr. Rayhack and Dr. Ellen Beatty, at the University of South Florida in Tampa, FL. After his nine years of residency training, he returned to the Mayo Clinic in Rochester, MN where he was actively involved in micro vascular and hand surgery in both the plastics and orthopedic hand surgery divisions. In 1993, he transferred to the Mayo Clinic in Scottsdale, AZ, after the retirement of Dr. George Irons, to assume the position of the director of the section of hand surgery and an attending in the plastic surgery division. In 1999, he left the Mayo Clinic to open his private practice in Scottsdale, AZ where he is presently actively involved in clinical practice doing general plastic surgery, hand surgery and cosmetic surgery.

Dr. Meland has been involved in the hand association leadership since 1990. His first appointment was as a member of the exhibits committee under the chairmanship of Dr. Robert Russell. Since that time, he has been elected and served as chairman of the exhibits committee, resident and fellowship award committee, time and place committee, membership committee and the finance committee.

He has actively served on the board as director at large for two years and most recently served as treasurer for four years, which also involved him being active as the financial chairman of the hand surgery endowment and being on their board for five years.

Dr. Meland is married to his wife, Sue, for 29 years. Sue continues to work as a physical therapist doing out-patient sports medicine. He has four daughters, Angela, who is married and lives in Fort Worth, TX. She is the Program/Outreach Coordinator for the Texas Christian University Institute of Child Development; Shaina, who is a senior at the University of Arizona in nursing; Jessica, who is a sophomore at Loyola Marymount University in Los Angeles, majoring in dance and art; Tessa, who is a freshman at the University of San Diego, studying pre-veterinary science.

Dr. Meland and his family are extremely humbled and honored to be able to lead the hand association in 2007-2008 and look forward to our upcoming meeting in Beverly Hills, CA.

LEADERSHIP PROFILE

AAHS NEW MEMBERS / JANUARY 2007

Active Members
Richard D. Battista, MD
Allentown, PA
Gary Branfman, MD, PA
Victoria, TX
William Ericson, Jr., MD
Bothell, WA
Eduardo Gonzalez-Hernandez, MD
Miami, FL
Thomas B. Hughes, MD
Pittsburgh, PA
Brian Labow, MD
Boston, MA
John Lomax, MD
Peoria, IL
Morgan Norris, MD
Houston, TX
Rene Recinos, MD
Mason City, IA
Mark Rekant, MD
Cherry Hill, NJ
David Thull, MD
Scottsdale, AZ

International Members
Abdulrahim Ali El-Gaiyar, MD
Benghazi, Libya
Abdel-Hakim A. F. Massoud, MD
Cairo, Egypt

Affiliate Members
Ann Marie Feretti, OTR/L, CHT
Bronx, NY
Douglas Huntley, PA-C
Corvallis, OR

Candidate Members
Jason Cacioppo, MD
Indianapolis, IN
Roshini Gopinathan, MD
Minneapolis, MN
Sharon Kim, MD
Rochester, MN
Nelson Lee Jenkins, MD
Worcester, MA
Rachel Rohde, MD
Southfield, MI
Chau Y. Tai, MD
Bakersfield, CA
al session with a fascinating discussion of the evolutionary forces that shapes and are still effecting hand function. Their symposium “Throwing darts at the back nine” was a rousing success.

Not to be outdone, Richard Berger provided insights into the current state of wrist and hand prosthetics. Donna Pendleton, the 2006 Vargas award winner, recounted her trip to Romania.

Concurrent free paper sessions filled out the remainder of the morning with over 20 presentations ranging from wrist biomechanics and injury to novel techniques, both experimental and clinical, in tendon repair.

Bob Jamieson, the ABC news correspondent, keynote speaker, and brother-in-law of President Ron Palmer spoke about his experiences in the heat of newsworthy events followed by a wide ranging question and answer session with the audience.

After lunch came another bevy of instructional course lectures covering topics such as the wide-awake approach to hand surgery to solving ulnar wrist pain, extensor tendon injury, distal radius malunion, burned hands, and PIPJ injury. The full day finished with a coding seminar by Dan Nagle on ways to maximize work unit value.

Friday began again on an early note with more instructional courses covering topics such as the wide-awake approach to hand surgery to solving ulnar wrist pain, extensor tendon injury, distal radius malunion, burned hands, and PIPJ injury. The full day finished with a coding seminar by Dan Nagle on ways to maximize work unit value.

Friday evening found the group at a Gershwin concert. Noted concert pianist and psychiatrist, Richard Kogan, eloquently emphasized the relationship of mind, medicine, and music on Gershwin’s creative output. His compelling account and exquisite playing including a tour de force rendition of Porgy and Bess, merited the standing ovation he received. That enthusiasm got the party started for the Awards dinner dance where speeches were kept to a minimum

The American Association for Hand Surgery would like to thank the following sponsors:

**Ascension Orthopedics**

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**Stryker**
ABC correspondent Bob Jamieson was a keynote speaker.

Dr. Richard Kogan plays Gershwin as part of his lecture.

Roberta Finley Morris, OTR/L, CHT, embraces the 2007 Vargas Award and the opportunity to travel to Sofia, Bulgaria.

The symposium “Throwing Darts at the Back Nine” covered ongoing evolutionary forces.

In addition to giving the J. Joseph Danyo Presidential Invited Lecture, Bob Beckenbaugh MD (left), takes time to conduct an instructional “hands on.”

Wet weather didn’t stop the dedicated from having a great time at the “Day at the Links” golf tournament.
AAHS 2007 Comprehensive Hand Surgery Review Course

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. Tomasso, MD, MBA

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

Distal Radius Fractures
Peter J. 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. Planche, MD, MS, FACS, FAAOS

Congenital Hand Differences
Scott H. Kozin, MD

Tumors of the Hand and Wrist
Edward A. Athanasian, 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

A must-have resource.

Purchase this special limited edition DVD and put the entire 2007 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 2007 Annual Meeting, it’s a resource you’ll turn to over and over again.

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www.handsurgery.org
and dancing to Kamaleon to a maximum.

After that wild night, it was a surprise to see a large audience in place early Saturday morning to hear a panel on upper extremity war injuries in Iraq chaired by Commander Erik Hofmeister. This was the combined meeting day of the AAHS, ASRM, and ASPN. All three presidents, Ron Palmer, Scott Levin, and Rajiv Midha welcomed the participants. Richard Gelberman, professor and chairman of Orthopedics at Washington University, and their invited lecturer gave a nuts and bolts inside look at how to manage a department of excellence. The remainder of the day was dedicated to nerve topics, including the six best nerve papers chosen by the combined societies, and a panel on Brachial Plexus Surgery 2007, moderated by Allan Belzberg and Robert Spinner. Inclement weather made the annual golf outing a water sport but did not deter the dedicated.

In summary, the 37th annual AAHS meeting, as have others in the past, provided an experience of education and collaboration—full of energy, full of fun, and full of friendship, the everlasting treasure of AAHS membership.
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Rapid Recovery

This issue's topic is taken from the Hand Therapy Specialty Day at the Annual Meeting in Puerto Rico. The moderator is Brian Adams, MD, Orthopedic Surgery, University of Iowa, Iowa City, IA. Joining him is panel co-chair, Ariva Wolff, Bsc, OTR/L, CHT, Hospital for Special Surgery in New York City, NY, and panel members Dorit Aaron, MA, OTR, CHT, FAOTA, Aaron & Rose Hand Therapy Services, Inc., Houston, TX, Michael Bednar, MD, Loyola University–Chicago, Maywood, IL, and Ron Palmer, MD, Assistant Clinical Professor, University of Illinois Medical School, Peoria, and Orthopedic Institute of Illinois, Great Plains Sports Medicine, Peoria, IL.

Dr. Adams: We recently had a symposium on rapid recovery, at the annual meeting which covered the topic of rapid recovery for both physicians and therapists. Dr. Palmer, I would like to start off by asking you about athletes, who may be the most demanding for rapid recovery. Can you tell us who might be typical candidates?

Dr. Palmer: Well, there’s a broad spectrum of athletes that come in. A lot of the work that we have done has been with our contact sports, particularly football. Our goal is to get our players back to their sport as quickly as possible. Certainly the coaches and players are anxious to get back. Often the families are also anxious to have them return to sport as quickly as possible and we have learned with time that there are appropriate ways to protect different athletes for different sports with different types of protective devices that will allow them to safely return to their sport and best participate in their sport. So that encompasses a great deal of available material.

Dr. Adams: What kind of protection would you normally recommend and how do you find the guidelines for that protection?

Dr. Palmer: Well there are all kinds of ways of taking care of injuries and protecting athletes from further injury. That can be with taping; it can be with commercially available types of splints; and it can be with fabricated type of devices. For fractures, actual casting for return to sport can enhance and protect the athlete. We use all of those things. We try to determine how stable the injury is, how best it can be protected, and what’s the minimum amount of materials that can be used to allow them to safely return to their sport and best participate in their sport. That encompasses a great deal of available material.

Dr. Adams: How about to a contact sport?

Ms. Aaron: That’s a double-edged sword because this one thing that would protect them can hurt someone else. So it all depends on what the rules of the sport are as to what we can put on them. Often they have to sit out until such time that appropriate protection meets the regulations.

Ms. Wolff: In my experience treating the professional athlete, the trainer or coach will either accompany the player to the therapy session or contact us to supply the information regarding the rules and regulations for the particular sport or game. We usually fabricate a thermoplastic splint out of a rigid material to restrict their movement and to protect the fracture or instability in a position that allows them to play. Athletic tape is used in place of Velcro to secure the splint to the hand. The trainer then covers the splint with foam at the regulated thickness before each game to protect other players.

continued
**AROUND THE TABLE**

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**Ms. Aaron:** That’s interesting. My experience recently with college football players that have injured their hands—both of whom required splinting—was that they were not allowed to play with the splints on. This was in the initial phase of healing.

**Dr. Adams:** Dr. Palmer, maybe you could tell us where you find the rules for acceptable splinting and casting.

**Dr. Palmer:** The NFL, all the professional sports have a specific set of rules. The rules for the NFL say that any protective device has to be covered by a quarter-inch thick of some sort of closed cell foam padding. The NCAA rule says that it’s a half-inch thick closed cell padding. We provide that at our sports medicine facility when we put the cast on to the athlete and cut it appropriately and then have them cover it with an ACE bandage and tape it on for sports.

The National Federation of High School Associations rule is exactly the same rule as the NCAA. I know because I wrote the rule for.

**Dr. Adams:** Michael, this brings up an important topic regarding the interaction between the therapist and surgeon in deciding the recovery program. How do you coordinate that?

**Dr. Bednar:** I think that providing good communication between the physicians and hand therapists is one of the most important things that we can do for our patients. I have a cadre of therapists that I work with at my institution as well as therapists who are in the community. I think it’s important for them to know what the extent of the injury was, how the injury was treated and what my expectations are in terms of how much motion is going to be allowed. But again, it’s an interaction.

**Dr. Adams:** How do you provide that interaction? By phone? By written report? By discussion through your nurses?

**Dr. Bednar:** All of the above. For the therapists who are at our institution, they’re always in the office with me, so conversations between the patient, the therapist and the physician, reviewing the x-rays, reviewing operative reports are important. For therapists who are off-site, I think the phone call is probably the best way of making sure that the therapists and physicians are on the same page.

**Dr. Adams:** What if the patient is a long distance away. In my area, patients may come from hundreds of miles away and you probably have similar patients. What would you do in that case?

**Dr. Bednar:** If the patient does not have a therapist that they’re familiar with, our therapists will help them to find someone in the area via the book of hand therapists. Once the patient makes contact with that therapist, I ask them to either send an email or phone message to me so that we can talk about the more complicated therapy programs.

**Dr. Adams:** Give us an example when you would not want a rapid recovery program.

**Dr. Bednar:** One group is patients in whom there are multiple soft tissue injuries with the fracture, such as patients who have had a significant crush injury. When there is a large area injury, including skin, veins, extensor/flexor tendons rapid recovery, trying to get patients moving within the first week, can cause more disruption. I think rapid recovery is best in patients in whom there is a lesser degree of injury, such as an isolated metacarpal or phalangeal fractures.
surgeon and therapist so that the guidelines be adjusted accordingly. At our facility, we have the advantage of being in close proximity to the surgeons. This coupled with the commitment to patient care allows for consistent, timely and open communication.

Ms. Aaron: I will concur that the most important information to convey to the therapist is any precautions, especially if they are specific to your repair or other condition of the patient that may not be common. If you have no time to communicate with the therapist, the most important information is the precautions: what not to do at a particular time.

Dr. Adams: Dr. Palmer, what’s your most challenging situation in attempting a rapid recovery program in an athlete? Or perhaps most importantly, under what circumstances would you advise your athlete against rapid recovery despite the coaches, family and athlete pushing hard to return to the sport?

Dr. Palmer: Well I think it’s very important that the physician be the one in control of when the athlete actually is allowed to return because if we are not comfortable with him returning, they should not return. The coach who comes in with the baseball players and hockey players here, always want the players back as quickly as possible and often, the players want that too. But the physicians must have and be comfortable about when the player goes back and that the injury is appropriately protected, so that he or she will not worsen the injury. Until you’re comfortable with that, you should not allow them to return and they cannot legally return.

Dr. Adams: I agree with Dr. Palmer. The coaches and many times the parents, even in the younger athletes are pushing hard for a return to the sport. Similarly, in workers compensation cases, the case managers and employers are requesting an early return to work. Many times I am not comfortable with the potential for rapid healing.

Dr. Bednar: When you’re developing a recovery program following an acute injury, for example a scaphoid fracture, do you change your treatment program based on the request of the family? For instance, casting versus internal fixation?

Dr. Bednar: I’ve become a strong proponent of internal fixation of scaphoid fractures particularly for the proximal third fracture where we know healing requires an extended period of casting. But even for the midwaist fractures, I’ll often offer both options to the patients, helping them understand the risks and benefits of internal fixation versus casting. After the discussion, many patients will say, "No thanks; I don’t want an operation." The other portion will say, "I would do anything to be out of that cast." So I let the patient decide what form of treatment they want.

Dr. Adams: When you’re dealing with workers compensation issues and the employer or case manager are requesting early return to work, how do you integrate the case manager into your decision plan?

Dr. Bednar: Well, the case managers of Illinois are a very active part of the care of the patient. They’ll often come to the appointments with the patients and want to know what the plan is. The questions they always ask at the end are when can the patient return to modified work, when can they return to full work and when would they be at a point of maximum medical improvement. I actually welcome them coming into the office because it’s a good time to have that discussion with the patient and the case manager about how we can mobilize that patient as quickly as possible. I’m not sure that they necessarily effect how we’re going to get things going more quickly, but it’s a good time to open the discussion about what is going to happen to the patient.

Dr. Adams: I would agree. In times past, case managers were considered a barrier to care, however I now believe they enable efficient care and reduce our workload. Ms. Aaron, do you as therapists have any interaction with the case managers in their recovery time?

Ms. Aaron: Usually I have had interaction with the case managers when I’m seeing patients at the physician’s office, which I do often. I give them a lot of instructions as to how to proceed with the patient. That’s the role I play: patient advocate. I explain to them what to expect as far as therapy. Case managers are very instrumental in making sure the patient gets what they need and that they progress through the system as fast as they can. They also make sure that patients show up for therapy. So I think they’re very helpful and a great avenue to assure rapid recovery.

Dr. Adams: Another group that can be quite demanding are the near-retired people who want to maintain a high activity level. In fact, many of these people want to become more active. They’re challenging because they’re abilities are usually less and yet their spirit is high. Dr. Palmer, do you approach that group any different than you would an athlete? For instance, 55-year old guy with wrist arthritis who wants to continue to play golf.

Dr. Palmer: Well I think that you have to inform them well about the expectations of the condition that they have. I mean, we do have some experience with dealing with some of these pathologic problems and probably have a much better way of informing them what the future holds for them than they do. I tell everybody that all I can do is rely on my past experience and
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Ms. Wolff: It’s been interesting to work with a broad range of young patients. It seems that children can be very accepting of new animal-assisted therapy if it’s used in a way that’s comfortable with that age group. Certainly, workman’s comp that I’ve handled tells me that one of the few things that they would like to have. Do you have any specific programs you’d recommend, for example golfing?

Ms. Wolff: We are in the process of developing a golf rehab program at the hospital for both postoperative and nonoperative patients. My colleague, Marc Friedman, PT has developed a detailed golf profile that includes medical history, health habits, and golf performance such as swing technique, flight of the ball, club use, and strengths and limitations of their game. This is followed by a comprehensive performance evaluation that looks at posture, balance, and muscle strength. The golf swing is videotaped, analyzed, and documented using a form that details the posture and position during each phase of swing. This provides the information that is necessary to design a specific golf rehabilitation program for each individual patient. We address range and strength limitations using weighted clubs and weighted hammers beginning with a half swing and progressing to a full swing. We also fabricate soft or semi hard splints to support the wrist and thumb if necessary. We have a variety of clubs in the clinic and ask patients to bring in their own if the splint needs to be molded so that it can accommodate the club shape.

Dr. Adams: Dr. Bednar, on the other end of the spectrum are children who can be encouraged by their parents to return to activities quickly, at least more quickly then we would like. How do you approach a child different than an adult?

Dr. Bednar: You know, as we talked about sports earlier, I’m always amazed that the number of times that I find out that the parents are convinced that the college scout is going to be at that particular football game right after the child has had the injury. I think it is important at some point, to get the child away from the parent and find out what the child really wants in addition to what the parents are looking for. Many times, particularly with repetitive strain injuries, you find out that the interest of the child participating in the activity isn’t as high as the parents’ interest in it and the child is actually relieved when they’re told that they should lay off of sports for a while.

Dr. Adams: I think the child may not only be complaining because it hurts, but also because they’re looking for an alternative opinion or excuse to avoid the stressful activity. Ms. Aaron, how do you manage this situation? For example, a physician may refer a child to you for rehab but you discover a less than enthusiastic response?

Ms. Aaron: Only for the positive. Well, first of all, I think that children recover rapidly—in and of themselves. I find myself slowing them down rather than speeding them up and protecting them longer rather than shorter, especially the ones that have the energetic family and are in sports in a big way. Certainly I agree that you have to separate the child from the parent to make sure that you have a true idea of what’s happening and sometimes even contact the coach as to realistic expectations and timetables. But once they’re healed, I still like to protect them a little bit longer than adults when they go back to play.

Now one of the things that I think is wonderful that’s available out there—obviously most clinics don’t have the sophisticated set-up that Ms. Wolff has in her clinic—is virtual reality games. Many of the activities that our young patients want to play may be harmful to their healing part. When you have that discrepancy, one can do an activity analysis and decide what it is that they have—or at times, want—to do. One of the things that’s available now is virtual reality games that people can buy for their homes: it allows them to actually participate in their sport at home with their TV without any stress or loading to their joints. It is a win-win situation, particularly with the kids who can’t wait to be active. That’s something that I think looking into the future might be a very interesting way of making them feel that they’re participating in their recovery. Some clinics now have virtual reality rooms for this purpose alone.

Dr. Adams: How do you monitor compliance of a recovery program? For example, not every 16 year old is going to follow your recommendations.

Ms. Wolff: I think that’s something that you intuitively pick up as a clinician when you’re working with patients. Which are those patients that are compliant and which aren’t? The progress speaks for itself, and the frequency of visits is adjusted accordingly.

Dr. Adams: Dr. Palmer, in your practice you have quite a few athletic trainers. How do you incorporate trainers in the program as well as monitoring compliance?

Dr. Palmer: Well we’re very fortunate because we do employ a num-
ber of athletic trainers. Our athletic trainers visit all of the training rooms around central Illinois except those that hire their own and that’s the major colleges and professional sports. But even our trainers go to some of those facilities on a regular basis and they have clinics at those facilities and see our patients and follow up with the athletes and make sure that they are complying with the programs we put them on.

Dr. Adams: Dr. Bednar, you treat quite a few trauma patients. Are there particular issues regarding young, active injury-prone patients?

Dr. Bednar: All of the above. I think those patients are seen more frequently. Again, I’m going to rely on my hand therapists a lot to help me with the management of those patients even if I’m seeing them every week or twice a week. My visit is going to be five to 10 minutes versus a therapist who’s going to spend an hour with them two to three times a week. So the insights that she gains from seeing those patients concerning how active they are during the course of therapy and how willing they are to participate in their therapy gives me a lot of clues about how motivated a patient is to get back into a rapid recovery mode.

Dr. Adams: Ms. Aaron, if you have a patient who you believe is not being compliant with your program and that is altering the outcome, how do you discuss the problem with the physician, or do you?

Ms. Aaron: Well first of all, it depends if it’s a child or an adult. If it’s a child, I would first try to explain very carefully to the parents the importance of them complying. I’ve been in situations where that caused a lot of friction between the parents and the child, and the parents will say, “You talk to the child; he doesn’t listen to me.” We become a psychotherapist. Those situations are difficult. Often you do need to involve the physician so that he/she talks to the parents or the child to impress upon them that there is a window of opportunity to get well and if you don’t use it, once the tissues heal, we can’t make as much difference.

As far as communicating with the doctor, I communicate on a very regular basis with reports, emails and phone calls, certainly if anything does not go according to plan. I don’t believe in evaluating patients once a month. I’m a big believer in evaluating, at least in part, every time you put your hands on a patient. Every time you see them you should know if you’re making progress not only from the time before, but from every modality and activity that you utilize. You should evaluate if it made a difference from the time before or even within a session. Any changes should be communicated to the doctor, in writing.

I’ve been involved in a research project for tele-rehabilitation that might answer the question you’d asked originally: how do we control compliance. How do we know what they’re doing? It is very difficult; the literature constantly reports that patients do not follow the frequency that we suggest with their home programs. One of the things that tele-rehab can do is keep a tally on every time the patients do their exercises. I think that’s the future.
Dr. Adams: In today’s Internet world patients may find reports of expected treatment and outcomes. Certainly many websites promote certain treatments and potential outcomes that may or may not be true for every patient. Do you incorporate web-based material in your rehab teaching?

Ms. Aaron: The Internet is a wonderful adjunct to patient education, however we need to be alert to the information that is out there that may not be in our patients’ best interest. I often make my own handouts for patient education and home programs. With computers, Internet and digital cameras, it’s very easy to have home programs that are specific to the patient. Sometimes I will also suggest Internet sites that I think would be helpful to them.

Dr. Adams: Dr. Bednar, do you use electronic media for patient education?

Dr. Bednar: Our therapists have a number of pages of home exercise programs that are designed for each of the different conditions that we’re treating. If the patients are only doing their therapy for the couple hours that they’re in therapy, they’re missing the opportunities of continuing these programs while at home. So both for the patients and as well as the parents of our pediatric patients, programs for continuing what they’ve learned in the therapy unit are provided.

Dr. Adams: Dr. Palmer, do you utilize commercial products?

Dr. Palmer: Not really. I mean, our office is exactly the same way. Our therapists have individualized for each of the 10 different physicians we have in the office their preferred protocols for the conditions that they take care of. We do take advantage of some of the commercially available pamphlets and literature that I know aren’t necessarily 100 percent like what I would like told to the patient but that does give them some information. I can’t tell you how many times a day I tell people to Google something and they’re very happy to find out how to get some information over the Internet.

Dr. Adams: Ms. Wolff, in your complex rehab organization, how do you deal with the differences among physicians and protocols regarding rehab programs for essentially the same conditions?

Ms. Wolff: We have variations in the protocols based on the surgeons’ preferences and the preferred surgical procedure, which also differs amongst physicians. All of our home programs are digital so it’s very easy to make a quick adaptation which we do anyway to adapt to the specific needs of the patient.

Dr. Adams: Well, that’s all for this session. Good night everybody, and thank you.

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2008 Application for Research Grants

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

Awards and Eligibility

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

Grant Application

Applications may be obtained from 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 5, 2007, 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

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HAND THERAPY PROFILE

Lynn Bassini, MA, OTR, CHT

**Personal:** I grew up in Guatemala until the age of 18 and consider myself very much a combination of Guatemalan and American. One of my passions is bringing my American friends and colleagues to Guatemala to share in the beauty of the country and the culture but also to help those in need. My children are truly my greatest source of pleasure, pride and purpose! Mona is 24 years old, a graduate of Boston University and currently in charge of Fundraising and Event Planning for the Guatemala Healing Hands Foundation. Andrew is 19 years old and a sophomore at SUNY Binghamton University. We are fanatic Yankee fans, enjoy theatre, travel and fabulous dining around the world.

**Education:** I came to the US in 1973 to attend the University of Pennsylvania. I graduated with a degree in Occupational Therapy and in 1977 moved to New York City. I obtained a graduate degree in Biomechanics and Ergonomics from New York University. I initiated my career as a hand therapist the year ASHT was founded in 1977 and became a CHT in 1991.

**Employer:** I have basically been in private practice, in Brooklyn, New York for my entire career. A large part of my day is filled with activities related to charitable causes.

**AAHS Involvement:** I have been a member of AAHS for over 20 years and my participation has been continuous. I was honored to receive the Vargas Award in 1998 and travel with my mentor, Dr. A. Freeland, to Venezuela. I was on the Board of Directors for AAHS and organized the 2004 Vargas Award to Guatemala City, whose recipient Sharon Dest, PT CHT has become a very crucial part of the Guatemala Healing Hands Foundation. I truly enjoy the sharing, learning, socializing and stimulating opportunities that this association provides.

**Best Part of My Job:** When that child comes into my office with a hand problem, I see the sadness yet hope in the parents’ faces; when the patient with the freshly surgically repaired tendon enters my front door, I begin to feel that bond that will develop among all of us, until the day of discharge, and often beyond. The desire to help and partner with these people and their physician, toward the common good of getting the patient back to normal is why I love my work. I can make a difference in the lives of others with my hands, heart and mind!

**Major Accomplishments:** My own children, improving someone’s life on a daily basis, building a private practice, earning the trust of my referring physicians, colleagues and patients, founding Guatemala Healing Hands Foundation, organizing and leading medical missions. As a recipient of the AAHS Vargas International Hand Therapist Teaching Award and ASHT’s Paul Brand Award for Professional Excellence, I am profoundly touched by my mentors and colleagues who have acknowledged what to me is not work, but simply my passion!

**Clinical Specialties:** All types of splinting including pediatric. The orthopaedic upper extremity patient including, congenital, fracture management, tendon, nerve, CTDs. Problem solving hand therapy, especially the complicated cases!

**Greatest Challenge:** Balancing all the aspects of my life, especially trying to get some sleep is a challenge for me! Having patience while trying to communicate with insurance companies as to why they should not deny the patient coverage for hand therapy, dealing with all the paperwork required, and an inefficient system that does not acknowledge the value of our services is definitely a frustrating challenge!

**Three Words That Describe Me:** Dr. Mukund Patel, hand surgeon I have worked with for over 25 years, describes me in three words: empathy, respect and a team player. My daughter Mona, had to say it in four words: giving, dedicated, loyal and punctual.
AAHS Mentoring Program

A new program was introduced in 2005, 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

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<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>
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<td><a href="mailto:berger.richard@mayo.edu">berger.richard@mayo.edu</a></td>
<td>Wrist surgery</td>
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<td>Rheumatoid and congenital</td>
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<td>Congenital hand anomalies and upper and lower extremity reconstruction for deficits due to trauma, cancer resecation or neurological disorders (i.e. brachial plexus)</td>
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<td>Pediatrics</td>
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<td>Don Lalonde, MD</td>
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<td>Wide awake approach to hand surgery</td>
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<td>W. P. Andrew Lee, MD</td>
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<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>
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<td>Wrist arthroscopy and endoscopic carpal tunnel release</td>
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<td>Michael Neumeister, MD</td>
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<td>Jorge Orbay, MD</td>
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<td>A. Lee Osterman, MD</td>
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<td>Advanced wrist arthroscopy and small joint arthroscopy. Can also mentor a topic such as DRUJ problems, or wrist fracture.</td>
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<td>Harvard Medical School 617-732-6390</td>
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<td>Michael Raab, MD</td>
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<td>Corrective osteotomy (volar or dorsal) of distal radius malunion with iliac crest bone grafting</td>
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<td>Jaiyoung Ryu</td>
<td><a href="mailto:jryu@adelphia.net">jryu@adelphia.net</a></td>
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<td>David Slutsky, MD</td>
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<td>Wrist arthroscopy and arthroscopic repair of dorsal radiocarpal ligament tears; intra-articular distal radius fractures</td>
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Recurrence Carpal Tunnel Syndrome

The topic for this Coding Corner is recurrent carpal tunnel syndrome. We will look at codes for re-exploration of the median nerve as well as adjunctive procedures that can be performed for this condition.

There is no specific code that corresponds to a repeat (or exploration for “recurrent” carpal tunnel syndrome), so the primary code that would be used is the one that describes opening of the carpal tunnel. This would be 64721 for an open approach and 29848 for an endoscopic approach. (Obviously, the endoscopic method is less likely to be used for repeat exploration.) Use of a modifier may be helpful to indicate the additional complexity of operating through scar tissue. The modifier -22 might seem appropriate, although insurers are sensitive to its overuse and typically require an additional letter of explanation that explains why this modifier applies. The modifier -60 might be better; it refers to operating through “an altered surgical field” as was created in 2001 to address the increased complexity or time required to perform surgery in revision cases that involve additional scar from previous surgery, infection, radiation, or distorted anatomy for any other reason. It is not completely clear which modifier, -22 or -60, will reimburse better, and you may have to track your particular reimbursement data to know which one is more appropriate for your particular payor mix.

Other procedures that might apply to the scenario of recurrent CTS include use of the operating microscope to perform an internal neurolysis. This corresponding code is 64727 and this is reported separately to the primary code for the carpal tunnel release. The code 64727 takes into account use of the microscope, and it is not appropriate to add 69990 to this code.

Performance of a flexor tenosynovectomy may also be a consideration in re-exploring the carpal tunnel, and the corresponding code is 25115. Use of a hypothenar fat pad flap to cover the nerve after exploration would correspond to a code for adjacent tissue transfer; an appropriate code would be 14040, which describes adjacent tissue transfer or rearrangement for the hands for a defect of 10 square centimeters or less.

Some additional procedures are occasionally indicated for patients undergoing a carpal tunnel release. Sometimes an opponensplasty tendon transfer may be warranted if the patient has good thumb passive mobility but limited active opposition due to severe thenar atrophy. If a superficialis opponensplasty were performed, then code 26490 would be used as an add-on. Codes 26492, 26494, and 26496 correspond to tendon transfers with a free graft, hypothenar muscle transfer, and opponensplasties performed via other methods, respectively. If a donor tendon were chosen from the wrist or forearm level, such as the palmaris longus, then code 25310 (tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single, each tendon) would be appropriate. If the forearm or

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<tr>
<th>Recurrent Carpal Tunnel Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>64721</strong> Neuroplasty, median nerve at the carpal tunnel</td>
</tr>
<tr>
<td><strong>29848</strong> Neuroplasty, endoscopic approach, median nerve at the carpal tunnel</td>
</tr>
<tr>
<td><strong>64727</strong> Internal neurolysis, requiring use of the operating microscope (includes external neurolysis)</td>
</tr>
<tr>
<td><strong>25115</strong> Radical excision of bursa, synovia of wrist, or forearm tendon sheaths; flexors</td>
</tr>
<tr>
<td><strong>14040</strong> Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq. cm. or less</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carpal Tunnel Release and Associated Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>64721</strong> Neuroplasty of the median nerve at the carpal tunnel</td>
</tr>
<tr>
<td><strong>29848</strong> Endoscopy, wrist, surgical, with release of the transverse carpal ligament</td>
</tr>
<tr>
<td><strong>26490</strong> Opponensplasty, superficialis tendon, without free tendon graft, each tendon</td>
</tr>
<tr>
<td><strong>26492</strong> Opponensplasty, with free tendon graft (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td><strong>26494</strong> Opponensplasty, hypothenar muscle transfer</td>
</tr>
<tr>
<td><strong>26496</strong> Opponensplasty, other methods</td>
</tr>
<tr>
<td><strong>25310</strong> Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single, each tendon</td>
</tr>
<tr>
<td><strong>25312</strong> Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single, with obtaining tendon graft(s) (includes obtaining graft), each tendon</td>
</tr>
<tr>
<td><strong>25115</strong> Radical excision of bursa, synovia, wrist, flexors</td>
</tr>
</tbody>
</table>
wrist donor tendon is used with a tendon graft, then code 25312 is the correct add-on code.

Recent papers have described Z-lengthening of the transverse carpal ligament after releasing it in order to reduce scar formation and reduce pillar pain. If this were done, an appropriate code would again be 14040.

Several papers in the past 5 years have identified use of either veins or “nerve tube” materials as useful in wrapping around scarred nerves in order to reduce recurrent adhesion formation. At the present time there are no specific codes that describe use of vein or synthetic conduits to treat nerve adhesions, and the best approximation of such work might be to use an internal neurolysis code or use of a nerve cable graft (with respect to the corresponding length and appropriate anatomic location) and write a letter of explanation to the insurer. The letter of explanation may be the only way to achieve reimbursement for your work.

Noted below are codes associated with recurrent carpal tunnel surgery as well as neuroplasty and nerve grafting codes.

### You Code It

A 72 year old diabetic patient undergoes re-exploration of the carpal tunnel for recurrent symptoms after her index procedure five years ago. She has re-release of the transverse carpal tunnel, a flexor tenosynovectomy, and a hypothenar fat pad flap used to protect the nerve during closure.

Solution: Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64721-60</td>
<td>Neuroplasty, median nerve at carpal tunnel (open, not endoscopic)</td>
</tr>
<tr>
<td>25115-51</td>
<td>Nerve graft, each additional nerve; single strand; arm or leg; up to 4 cm in length</td>
</tr>
<tr>
<td>14040-51</td>
<td>Nerve graft, each additional nerve; multiple strands; list in addition to code for primary procedure</td>
</tr>
<tr>
<td>25115-51</td>
<td>Nerve graft, each additional nerve; single strand; list in addition to code for primary procedure</td>
</tr>
<tr>
<td>14040-51</td>
<td>Nerve graft, each additional nerve; multiple strands; list in addition to code for primary procedure</td>
</tr>
<tr>
<td>25115-51</td>
<td>Nerve pedicle transfer; first stage</td>
</tr>
<tr>
<td>14040-51</td>
<td>Nerve pedicle transfer; second stage</td>
</tr>
</tbody>
</table>

### Neuroplasty (Exploration, Neurolysis, or Nerve Decompression)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64702</td>
<td>Neuroplasty, digital, one or both, same digit</td>
</tr>
<tr>
<td>64704</td>
<td>Neuroplasty, nerve of hand or foot</td>
</tr>
<tr>
<td>64708</td>
<td>Neuroplasty, major peripheral nerve, arm or leg, other than specified</td>
</tr>
<tr>
<td>64712</td>
<td>Neuroplasty, sciatic nerve</td>
</tr>
<tr>
<td>64713</td>
<td>Neuroplasty, brachial plexus</td>
</tr>
<tr>
<td>64714</td>
<td>Neuroplasty, lumbar plexus</td>
</tr>
<tr>
<td>64716</td>
<td>Neuroplasty and/or transposition; cranial nerve (specify)</td>
</tr>
<tr>
<td>64718</td>
<td>Neuroplasty, ulnar nerve at elbow</td>
</tr>
<tr>
<td>64719</td>
<td>Neuroplasty, ulnar nerve at wrist</td>
</tr>
<tr>
<td>64721</td>
<td>Neuroplasty, median nerve at carpal tunnel (open, not endoscopic)</td>
</tr>
<tr>
<td>64722</td>
<td>Decompression, unspecified nerve(s); specify</td>
</tr>
<tr>
<td>64726</td>
<td>Decompression, plantar digital nerve</td>
</tr>
<tr>
<td>64727</td>
<td>Internal neurolysis, requiring operating microscope; list in addition to code for neuroplasty; includes 69990 code for microscope</td>
</tr>
</tbody>
</table>

### Neuroplasty Using Special Operative Techniques

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64885</td>
<td>Nerve graft (includes obtaining graft); head or neck; up to 4 cm in length</td>
</tr>
<tr>
<td>64886</td>
<td>Same as above (64885) except graft is more than 4 cm in length</td>
</tr>
<tr>
<td>64890</td>
<td>Nerve graft (includes obtaining graft); single strand, hand or foot; up to 4 cm in length</td>
</tr>
<tr>
<td>64891</td>
<td>Same as above (64890) except graft is more than 4 cm in length</td>
</tr>
<tr>
<td>64892</td>
<td>Nerve graft (includes obtaining graft); single strand; arm or leg; up to 4 cm in length</td>
</tr>
<tr>
<td>64893</td>
<td>Same as above (64892) except graft is more than 4 cm in length</td>
</tr>
<tr>
<td>64895</td>
<td>Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot, up to 4 cm in length</td>
</tr>
<tr>
<td>64896</td>
<td>Same as above (64895) except graft is more than 4 cm in length</td>
</tr>
<tr>
<td>64897</td>
<td>Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg, up to 4 cm in length</td>
</tr>
<tr>
<td>64898</td>
<td>Same as above (64897) except graft is more than 4 cm in length</td>
</tr>
<tr>
<td>64901</td>
<td>Nerve graft, each additional nerve; single strand; list in addition to code for primary procedure</td>
</tr>
<tr>
<td>64902</td>
<td>Nerve graft, each additional nerve; multiple strands; list in addition to code for primary procedure</td>
</tr>
<tr>
<td>64905</td>
<td>Nerve pedicle transfer; first stage</td>
</tr>
<tr>
<td>64907</td>
<td>Nerve pedicle transfer; second stage</td>
</tr>
</tbody>
</table>
### American Association for Hand Surgery Calendar

#### 2007
- **July 12-14, 2007**
  - Mid-Year Board of Directors’ Meeting
  - Silverado Resort
  - Napa, CA
- **October 4–7, 2007**
  - ASHT Annual Meeting
  - Phoenix, AZ
- **October 26–31, 2007**
  - ASPS Annual Meeting
  - Baltimore, MD

#### 2008
- **January 9–12, 2008**
  - 38th Annual Meeting
  - The Westin Century Plaza Hotel & Spa
  - Beverly Hills, CA
- **March 5–9, 2008**
  - AAOS Annual Meeting
  - San Francisco, CA
- **July 11–13, 2008**
  - AAHS Mid-Year Board of Directors Meeting
  - The Ritz Carlton, Laguna Niguel
  - DanaPoint, CA
- **October 23–26, 2008**
  - ASHT Annual Meeting
  - Boston, MA
- **October 24–29, 2008**
  - ASPS Annual Meeting
  - Honolulu, HI

#### 2009
- **January 7-10, 2009**
  - 39th Annual Meeting
  - Grand Wailea Resort
  - Wailea, Maui, HI
- **February 25–March 1, 2009**
  - AAOS Annual Meeting
  - Las Vegas, NV
- **September 2–5, 2009**
  - ASHT Annual Meeting
  - San Francisco, CA
- **October 23-28, 2009**
  - ASPS Annual Meeting
  - Chicago, IL

#### 2010
- **January 6-9, 2010**
  - 40th Annual Meeting
  - Boca Raton Resort & Beach Club
  - Boca Raton, FL
- **October 1-6, 2010**
  - ASPS Annual Meeting
  - Toronto, Canada

#### 2011
- **January 12-15, 2011**
  - 41st Annual Meeting
  - Ritz Carlton Cancu
  - Cancun, Mexico
- **September 23-28, 2011**
  - ASPS Annual Meeting
  - Denver, CO

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### Inside This Issue:
1. 2007 Annual Meeting in Review
2. From the President
3. Association News
4. 2007 Award Winners
5. Leadership Profile: N. B. Meland, MD
6. Around the Hand Table: Rapid Recovery
7. Hand Therapist Profile: Lynn Bassini, MA, OTR, CHT
8. Mentoring Opportunities
9. Coding Corner: Recurrent Carpal Tunnel