WHERE IS ROMANIA? Very good question! For starters, we decided to include a very brief introduction of this little known country somewhere in Europe to set the stage for our sojourn to this beautiful country. Romania is in southeast Europe and is slightly smaller than Oregon. The Ukraine is up north and bounded by Moldova in the east; the Black Sea is southwest; Bulgaria in the south; Yugoslavia is southwest and Hungary is just northeast.

Romania’s post WWII history as a communist-block nation is more widely known, primarily due to the excesses of the former dictator Nicolae Ceausescu. In December 1989 a national uprising led to his overthrow. The 1991 Constitution established Romania as a republic with a multiparty system, market economy and individual rights of free speech, religion and private ownership. Romania is now a full member of the European Union since January 2007.

Romania’s capital, Bucharest, is an overnight train ride southeast of Cluj-Napoca where we were hosted in the fall of 2006 by Drs. Alexandru and Constanza Georgescu. Cluj-Napoca or Cluj, is a city in north-western Romania and is one of the most important academic, cultural and industrial centers in the country. It is located in the historic province of Transylvania.

Dr. Alexandru Georgescu, is the Chief of the Plastic Surgery Department with an impressive staff of over twelve interns, residents, fellowship training physicians. He employs one physiotherapist to rehabilitate his hand cases. This physiotherapist, Octavian Olariu, is a trained kinesiotherapist.

In Romania, therapists seem to have distinct but confusing margins in their credentials. Different continued on page 8
Looking for a Few Good People

Five years ago, AAHS joined the AMA House of Delegates. Nick Vedder and I have been privileged to serve you there since then. During that time, we have participated in the debates as AMA addressed turf wars between specialties on who can use imaging equipment or perform certain procedures, between hospitals and doctors on the appropriateness of specialty hospitals, on ways to improve Medicare reimbursement, on adding new CPT codes, and in revising the AMA Code of Ethics, addressing such issues as the ethics of industry representatives in the operating room, boutique practices, and the patenting of surgical procedures. AMA has led the fight on medical liability reform, on pay for performance and on many other issues of critical importance to physicians. While in the past the AMA was dominated by the states, the specialties are on a path to achieve parity in numbers in a few years, although the final formula remains hotly debated. It has been an eventful time.

Membership also has its benefits. In addition to a subscription to JAMA and AMNews, and discounts on AMA products, such as the Guides to the Evaluation of Permanent Impairment and the CPT guides, we get the tremendous leverage of being a part of a far larger organization. Just five years of steady AAHS presence in the AMA House has put us in the position of being recognized spokespersons for hand surgery. Through our representation in the AMA House, we are able to bring forward resolutions and garner the support, and access to all the resources of the entire AMA operation if our resolutions are adopted. More importantly, as our faces have become known, Nick and I have begun to advance the AMA hierarchy. I have had the privilege of chairing a few subcommittees for the Specialty and Service Societies (S&S, or ‘triple S), the group within AMA where the specialties convene separate from the states, prior to coming together in the single House of Delegates. I also chair the Hand Surgery Caucus- there are about a dozen hand surgeons who are also AMA delegates, either for states or other specialties, and we meet together for a few hours at each AMA meeting to discuss issues of importance. This is powerful leverage. We have representation and thus leverage in both the orthopaedic and plastics caucuses as well, further extending our influence.

Every five years, the AMA requires its specialty society members to be reviewed, to be sure that they continue to meet the membership criteria: either 1000 members who are also AMA members, or, if there are fewer than 1000 AMA members, a minimum of 35% of the societies members must be AMA members. There is also an absolute floor, in that the society must in no case have fewer than 250 AMA members. Now it is time for AAHS to be reviewed. As a smaller society, the 35% threshold and the 250 minimum requirement are almost the same for us. Five years ago, we got in with a few members to spare. We need to do at least as well this time. If you are an AMA member, thank you. Please remember to renew your dues. If you are not, please consider joining. AMA is still not only the largest organization of American doctors by far, but also the only forum where ALL American doctors get together to speak with a single voice, whether it is to protect our right to practice medicine without lawyers and insurance companies peering over our shoulders at every turn, to establish our own definitions of professionalism and ethics, which is our right as a profession, or to advocate for fairness and justice in the many laws that regulate our practice and the health care provided to our patients.

Please join me, Nick Vedder and so many other AAHS members in belonging to AMA. It will allow us to keep our voice in the House of medicine, and keep us connected to the most important issues of the day. For your convenience, an application form is included in this newsletter. Or just log on to the AMA website (https://membership.ama-assn.org/JoinRenew/) and join today. Thanks!
Greetings to all of the members of the American Association for Hand Surgery.

The board met for their spring conference call the last week of April. Warren Schubert is looking at our by-laws and there will be some minor changes in regards to the emeritus members and some wording that was a little bit confusing in a few articles of the by-laws. We will have these changes mailed to you this fall, so any changes can be voted upon by the membership at our meeting in Beverly Hills.

George Landis is working hard and continues to do an excellent job on our website. If you haven’t visited it lately, we have a new face page and have dressed it up very nicely. I am very proud of George and the work he has done. He is also working on a couple of aspects to try and get us some CME credits through our instructional courses and other educational opportunities, which I believe would benefit our membership greatly.

The membership committee, under the direction of Steve McCabe and Carin Wulf, is waiting for applications. We have approximately ten to twelve new applications in now. If you have friends, associates or affiliates who wish to join, the application process is simple and can be done through our website www.handsurgery.org and I would recommend that everyone recruit a new member.

As you can see from your treasurer’s report in this month’s quarterly (page 11), the Association continues to do well from a financial standpoint. Thanks to the members coming to our annual meeting, since that is our main source of income. The members have also been excellent this year in getting their dues in promptly. We appreciate that.

The program committee, Mike Neumeister, Craig Johnson and Christine Novak, are finalizing the program at this time. I will update you further in regards to the scientific program in the next issue of the quarterly.

Peter Amadio and Nick Vedder, as you may or may not know, is our delegate and affiliate delegate to the AMA House of Delegates. They will be attending the annual AMA meeting this year in Chicago. They work very hard in this aspect representing hand surgery and the important political and economic aspects and the problems we are facing in our specialty. It has been brought to my attention that the AMA looks at our overall membership from the association every three years. We are up for review on this process next year. If 35% of the hand association are not members of the AMA, we may lose our seat in the House of Delegates. This would be grave and unfortunate. I therefore urge you to join the AMA, so we can maintain Peter and Nick’s seat in the House of Delegates, which is very important to have a vote and a word to continue our political and economic status as a specialty. Your consideration in this is greatly appreciated. We need to maintain this aspect of our outreach.

We completed the site visit to the Century Plaza in Beverly Hills, where our annual meeting will be held. I was very impressed. The hotel is beautiful and all of the rooms have been remodeled. The facilities in the convention center are outstanding and in close proximity to our hotel rooms. The hotel is immaculate and “star sightings” will be common, as we all ran into some stars during our two-day site visit. The hotel is in easy access to the Los Angeles airport as well as the Burbank airport. It is approximately a 30-minute cab ride from the airport to the hotel.

The hotel has a swimming pool, hot tub & spa located right next to the hotel. The spa is huge and has all of the aspects you would expect, including large workout facilities.

I hope you are all getting excited about our meeting in Beverly Hills. The weather should be in the 70’s during the day. I would suggest you bring a sweater and/or a coat, as it will be chilly at night with some ocean fog. The hotel has one large restaurant. My wife Sue and I ate there and the sushi was excellent. There is a mall one block away that has an excellent seafood restaurant and excellent Italian restaurant. We are approximately a half mile from Rodeo Drive, which is in easy walking distance.

Those of you with children and young families, I hope you bring them along. As far as activities, we are about 20 minutes from the Santa Monica pier and beach. There is 10 miles of walking, biking and hiking pathways with restaurants and shops and the pier has a very nice amusement park which your children can enjoy. We have always enjoyed our time on Santa Monica beach and Venice beach. It has great people watching and you can rent any type of transportation; bicycles, roller blades, etc. to get around on the beach. An afternoon there is well spent.

The Getty Museum is approximately 10 minutes from our hotel. It is an excellent art exhibit. The admission to the museum is free. It is a brand new facility and for those of you interested in the arts, it is a nice way to spend an afternoon.

continued
Outreach Opportunity

The Hand Surgery Endowment is pleased to announce an exciting volunteer opportunity within the Indian Health Service for AAHS members. The HSE is seeking a surgeon and therapist to provide education at the Shiprock and Tuba City service units located on the Navajo Indian Reservation. Volunteers will provide education/in-services to a medical staff audience (MD, PA, CNP, PT, OT) on the evaluation & management of common hand injuries and conditions. There may also be break-out sessions for both primary care providers and therapists for training in discipline-specific, hands-on skills.

**SHIPROCK** is the largest service unit in the Navajo Nation. Located on the San Juan River in the Four Corners area, the community is the focus of activity in this part of the reservation. The Shiprock hospital provides health care to more than 53,000 Navajos in the region. It is home to more than 80 physicians and dentists and a complete support staff of nurses and other health care providers.

**TUBA CITY** is located at the western edge of the Navajo Nation. The service area includes some 4,000 square miles of the Painted Desert. The general hospital serves approximately 22,000 Navajos, Paiute and Hopi Indians. A wide range of services are available at the Tuba City Regional Health Care Medical Center. There are also specialty clinics for persons with diabetes, surgical needs, and tuberculosis. The trip will be in October, 2007 and the surgeon and therapist will be funded $1,500 each for travel and lodging.

You should contact Laura Downes in the HSE Central Office 312.236.3307 or downes@isms.org if you are interested in participating.

The mission of the Hand Surgery Endowment is to promote, develop and conduct educational programs for surgeons and other health care professionals relating to hand surgery. In addition the HSE will identify, pursue and participate in existing outreach programs.

In closing, I again would like to thank the members of my board and all of the members I have called for appointments to ask to do teaching courses, speak on panels and who have submitted abstracts. I greatly appreciate your time. Everyone I’ve asked anything of this year has told me yes, which is amazing. I hope you are fired up, because the meeting in Beverly Hills is going to be outstanding and I look forward to seeing all of you there.

I will update you on the finalities of the speakers during my next address.

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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John McFadden, MD Recognized for Commitment to Global Health

Health Volunteers Overseas (HVO) recently announced that John McFadden, MD is a recipient of the second annual Golden Apple Award. As part of its World Health Day observances, HVO created this award as a way of recognizing the extraordinary educational contributions of volunteers to sites abroad. Each volunteer honored with this award has demonstrated a strong commitment to HVO’s educational mission by working on curriculum development, teacher training, didactic or clinical training, or the enhancement of educational resources.

Dr. McFadden was selected for this honor due to his dedication to the HVO hand surgery program in Honduras. Since 2004, Dr. McFadden has completed volunteer assignments with this program on a yearly basis. During his assignments, Dr. McFadden provides expert treatment to hand pathology patients at the Hospital Escuela. In addition to providing high quality patient care, Dr. McFadden also instructs the local plastic surgery training team and meets with them yearly to track their improvements. His knowledge and innovative techniques have honed the skills of the surgical team, while also exposing and training them in new surgeries, which otherwise would have never been performed in Honduras or even Central America.

Dr. Luis Gonzalez, the on-site coordinator for the hand surgery program described Dr. McFadden’s efforts by stating, “I believe he has been a cornerstone for the development of our hand surgery program; for his volunteer work is based on the adage of teaching a person how to fish, so that person will be able to feed himself for life.”

Dr. McFadden is a hand, upper extremity and microvascular surgeon on staff at the Charleston Hand Group/UMA in Charleston, South Carolina. Dr. McFadden is a member of the following professional affiliations: the American Society for Surgery of the Hand, the American Association for Hand Surgery, the American Society for Plastic and Reconstructive Surgery and the South Carolina Medical Association. He is also a fellow of the American College of Surgeons.

According to recent reports, the global shortage of health care workers is estimated to be 4.3 million. WHO Director-General Margaret Chan, MD commented on the health care shortage stating, “The simple fact is that the world needs many more health workers. The world faces global as well as local threats to health. Infectious diseases have staged a dramatic comeback, and chronic diseases are on the rise. We cannot improve people’s health without staff to deliver health care.”

“I am delighted that Dr. McFadden’s contributions to Honduras are being recognized with this award,” said Nancy Kelly, HVO Executive Director. “By highlighting the accomplishments of volunteers like Dr. McFadden, we hope to raise awareness of global health issues and of the role that individuals can have in making a difference.”

A private, non-profit membership organization, HVO was founded in 1986 to improve global health through education. HVO designs and implements clinical education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, infectious disease, nursing education, burn management and wound care. In more than 25 resource-poor nations, volunteers train, mentor and provide critical professional support to health care providers who care for the neediest populations in the most difficult of circumstances.
Below is a list of AAHS members who have generously offered to teach their expertise in specific areas, letting our members continue to learn the way we were taught, as residents and fellows, in the clinic and operating room with a surgical mentor. For more information, please contact the AAHS Central Office.

<table>
<thead>
<tr>
<th>NAME</th>
<th>EMAIL</th>
<th>PROCEDURE(S)</th>
</tr>
</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 carpmetacarpal; 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>Kyle Bickel, MD</td>
<td><a href="mailto:kbickel@shand.com">kbickel@shand.com</a></td>
<td>Vascularized bone graft reconstruction for carpal pathology; complex fracture management in the hand and wrist; and arthroscopic wrist ganlion excision</td>
</tr>
<tr>
<td>Allen Bishop, MD</td>
<td><a href="mailto:bishop.allen@mayo.edu">bishop.allen@mayo.edu</a></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 Contracture; thumb reconstruction; flexor tendon surgery; trapezial excision arthroplasty; and medial epicondylectomy</td>
</tr>
<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>
</tr>
<tr>
<td>E. Gene Deune, MD</td>
<td><a href="mailto:egene@jhmi.edu">egene@jhmi.edu</a></td>
<td>Congenital hand anomalies; upper and lower extremity reconstruction for deficits due to trauma; cancer resection; and 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>
</tr>
<tr>
<td>Don Lalonde, MD</td>
<td><a href="mailto:drdonlalonde@nb.aibn.com">drdonlalonde@nb.aibn.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>Susan Mackinnon, MD</td>
<td><a href="mailto:mackinnons@wustl.edu">mackinnons@wustl.edu</a></td>
<td>Ulnar nerve surgery</td>
</tr>
<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:OOGIE@aol.com">OOGIE@aol.com</a></td>
<td>Wrist arthroscopy; 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>
</tr>
<tr>
<td>Jorge Orbay, MD</td>
<td><a href="mailto:jlorbay@aol.com">jlorbay@aol.com</a></td>
<td>Wrist fractures</td>
</tr>
<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><a href="mailto:jprizaz@partners.org">jprizaz@partners.org</a></td>
<td>Soft tissue reconstruction; microsurgical reconstruction; spare parts surgery and extremity reconstruction</td>
</tr>
<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>
</tr>
<tr>
<td>Jaeyoung Ryu</td>
<td><a href="mailto:jryu@adelphia.net">jryu@adelphia.net</a></td>
<td>Wrist reconstruction; distal radius fracture; and scaphoid fracture/nonunion</td>
</tr>
<tr>
<td>David Slutsky, MD</td>
<td><a href="mailto:d-slutsky@msn.com">d-slutsky@msn.com</a></td>
<td>Use of volar wrist portals for wrist arthroscopy and arthroscopic repair of dorsal radiocarpal ligament tears; nonbridging external fixation of intra-articular distal radius fractures; nerve conduction studies for hand surgeons; and comparison of NCS and PSSD for the diagnosis of CTS</td>
</tr>
<tr>
<td>William Swartz, MD</td>
<td><a href="mailto:william.swartz@verizon.net">william.swartz@verizon.net</a></td>
<td>Tendon transfer and ulnar nerve</td>
</tr>
<tr>
<td>Thomas Tung, MD</td>
<td><a href="mailto:tungt@wustl.edu">tungt@wustl.edu</a></td>
<td>Brachial plexus</td>
</tr>
<tr>
<td>Joseph Upton, MD</td>
<td><a href="mailto:jupton3@earthlink.net">jupton3@earthlink.net</a></td>
<td>Congenital hand surgery</td>
</tr>
<tr>
<td>Elvin Zook, MD</td>
<td><a href="mailto:ezook@siumed.edu">ezook@siumed.edu</a></td>
<td>Fingertip reconstruction</td>
</tr>
</tbody>
</table>
than our traditional separations of occupational and physical therapist, these Romanian therapists distinguish their professional boundaries by subtle didactic training differences. In practice, these professional boundaries are repeated throughout the hospital setting by arranging like therapists in distinct and separate departments. Examples that we saw at the hospital, Spitalul Clinic de Recuperare, where we worked for three weeks, included electrotherapy being performed by electrotherapist, soft tissue work done in another department by massage therapists, and even rheumatological patients separated again in another area. Neurology has its own therapy, and so on. The system, different than therapy in the USA, more closely resembles the sub-specialization trends of the United States physicians.

Cluj-Napoca was our host city and we worked in an emergency-recuperative hospital, the Spitalul Clinic de Recuperare. This hospital was home to approximately twelve floors of trauma patients. It became home for many months to patients with several staged procedures and home to any patient whose home was in the countryside, often 3-6 hours travel from Cluj-Napoca. The hospital spent immense resources housing patients, often allowing their recuperative hospital stay to last months as the physician waited for wounds to heal and recover sufficiently to receive second and tertiary staged surgeries. This was fascinating for us. Now the US system will not let even sick people stay in the hospital for sufficient recovery, while the Romanian system was allowing patients a hospital bed simply to guarantee they receive their subsequent surgical procedures. This practice would likely make a good US insurance carrier reel!

Housing patients in shared rooms, usually six patients per room, seemed to bring us back to black and white photos of WWII veteran illustration books. In Romania, these rooms become the family gathering place during the day, with the family responsible for the basic care of the patient during the day, from bringing soaps and personal care items, to assisting them to and from the common bathroom at the end of the hallway. Patients spend a great deal of time in their beds, and idle most of their weeks waiting for news of their next surgery; often surgery stages being decided one day and performed the next. Patients are bandaged on the floor by the physicians around 6AM. During the therapy session, bandages and dressings remain untouched, not allowing for visual wound inspection or for better understanding of the extent of the injury. This tradition of not permitting wound care activities in therapy has a great effect on the rehabilitation process and final result. Simply, wounds are left to scar, and do so with abandon, and these scar processes created significant adhesions, loss of joint motion, and permanent deformities that could be preventable with greater confidence in therapeutic interventions of wound care and scar management.

These topics were shared in Romania, with attention to scar management being critical if the wound care could not be added to the therapy regime. The use of scar management tools such as foam to replace silicone (not available in Romania) and the use of massage, vibration, and other techniques were simple and effective additional armamentarium for the therapists to implement.

Splinting in Romania requires great imagination. Octavian Olariu prides himself in the use of plaster casting to substitute for thermoplastic, which are not available. He is...
adept and innovative in using this medium. His use of dynamic extension outriggers with plaster was impressive, but the protocols for timeframes and indications for dynamic extension were often conflicting with US standards of practice. For example, during post-op week one, we were surprised to see a flexor tendon repair placed in dynamic extension outriggers. This protocol is under careful scrutiny by Dr. Georgescu, and he predicts these patients will recover similar or even better than our classical Modified Duran passive protocol or even the early Active Mobilization protocol used in the US. The jury is out on this one still for us, but we have to share with you that Dr. Georgescu was able to show us many images of flexor tendon repairs treated in this novel way with good final clinical and functional results.

A hardship in our work was desiring the details we were often lacking. The value of operative reports and radiographic images became better appreciated by us in Romania. Often, charts were not available, details of the surgery were brief verbal physician reviews, wounds were forbidden to be exposed, and specifics had to be shrouded beneath the gauze. These made therapy practice one of what it could-be and running through the “safe zone” only. Our capabilities as therapists are intimately connected to the detail of the surgery and the knowledge of the do’s and don’ts of these surgeries. We found Romania to limit the detail we desired. Without the detail, we struggled to match the “perfect therapy” intervention to each patient. That is great for everyone! Use the basic again like edema control, passive range of motion, and make these basics work to the patient’s advantage. Making our interventions safe in a shroud of gauze became our work.

One of the highlights of our stint in Romania was our participation in the Second International Course of Hand Surgery and Hand Therapy held at Spitalul Clinic de Recuperare in Cluj-Napoca which was a three-day event attended by surgeons, medical students and therapists from all over Europe. Invited speakers presented their areas of expertise which included surgical techniques and rehabilitation management. Luckily for us, the whole course was conducted in English! The conference offered a unique opportunity for the participants in that we had a half-day splinting lecture and lab. The attendees had hands-on experience in making simple splints; surgeons, students and therapists alike.

It is with pride and pleasure to report that we became charter members of the Romanian Hand Society. The task to unite therapists from all over Romania was a difficult process but with a very positive outcome. Hopefully, the Romanian Hand Society will thrive and survive the growing pains of a new organization.

Our experience was enriching.
Ulnar Sided Wrist Pain

The topic for this issue of the Coding Corner is ulnar sided wrist pain, and we will look at procedures more commonly performed for this condition.

Wrist arthroscopy is commonly used to both diagnose and treat ulnar sided wrist pain. The relevant code family is from 29840 through 29847, summarized in the table below. Code 29840 refers to just a diagnostic wrist arthroscopy; surgical lavage for infection corresponds to 29843. A partial synovectomy is coded with 29844, whereas complete synovectomy corresponds to 29845. Treatment of the triangular fibrocartilage is coded with 29846, and arthroscopic treatment of a fracture with internal fixation is coded with 29847. There is no specific code for arthroscopic treatment of a distal radius fracture, although some insurers may reimburse both for use of the appropriate distal radius fracture code as well as a suitable arthroscopy code.

Ulnar sided wrist pain is sometimes related to intrinsic ligament problems of the wrist and/or issues around the distal ulna. The code 25320 corresponds to a capsulorrhaphy or reconstruction of the wrist. Code 25237 is used for reconstruction or stabilization of an unstable distal ulna using a soft tissue procedure. Shortening the distal ulna would correspond to code 25390, whereas an intra-carpal shortening, would be coded with 25394.

Some salvage procedures may also come into play for treating ulnar sided wrist pain. A limited fusion of the wrist, such as a four corner fusion, would be coded with 25280 (or 25825 if autograft is used). Fusion of the distal radioulnar joint (i.e. Sauve-Kapandji procedure) would be coded with 25830.

You Code It

A 42 year old woman presents with a long history of ulnar sided wrist pain that ultimately is shown to be related to an old distal radius fracture and distal radioulnar joint incongruity and arthritis. You elect to perform a distal radioulnar joint fusion to improve forearm rotation and reduce pain.

Solution: Code 25830
I present the Treasurer’s Report for the the year ending December 2006 and am happy to report that the Hand Association remains on solid ground. This is again a tribute to the leadership of our past president Ron Palmer, president Brad Meland, president-elect Scott Kozin and vice-president Nick Vedder 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 a debt of gratitude to Jeff Palmer with Smith Barney, who has managed our investments in this volatile market for the past several years.

Despite a drop in membership dues, a very successful meeting in Puerto Rico, increased advertising sales for the quarterly newsletter, a successful spring symposium, and favorable long term investment income boosted revenue markedly. Income from some of these revenue sources is shown in Table 1.

Unfortunately, along with the rising revenue stream, the cost of running the organization continues to climb. The increased expenses can be attributed to several factors. The annual meeting expenses were approximately 20% over budget due to the additional cost of cadaver courses. In addition, publication costs jumped nearly two and one half times due to the launch of the new journal HAND and a redesign of the AAHS web site (part of which was funded by the Hand Surgery Endowment). Lastly the management fees continue to climb, not unexpectedly. 2006 expenses are shown in Table 2 along with the preceding three 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 with the organization and to invite new members from their fellow hand surgeons and therapists. This will insure the continued viability and success of our excellent association.

As noted in last year’s report, I am also the treasurer of the Hand Surgery Endowment. During the last two years, under the leadership of past-president Alan Freeland and recently-elected president William Swartz, the HSE has been revitalized thanks to the contributions of many of our members as well as a few corporate donors. The HSE’s focus has also been redirected to outreach missions both to provide a great service and to position itself for increased contributions from corporate or philanthropic donors in the future. As in the past, the HSE continues to encourage the members of the AAHS to give generously for the ongoing success of its mission.

This concludes my last AAHS Treasurer’s Summer Report. It has been my pleasure over the past three and one-half years to serve the members of the AAHS. Starting next January, Dr. Mark Baratz will assume the treasurer position. As treasurer-elect, he has kept abreast of the financial status of the AAHS and I’m sure he will exhibit due diligence over your funds. As always, 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.

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

![Richard E. Brown, MD](image)

**Table 1**

<table>
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<th>Income</th>
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**Table 2**

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**Table 3**

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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
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Ulnar-Sided Wrist Pain

This issue’s topic is moderated by John Bednar, MD, Assistant Professor of Orthopaedic Surgery, Jefferson Medical College of Thomas Jefferson University, and The Philadelphia Hand Center, Philadelphia, PA. The panel members are hand surgeons Peter Murray, MD, Department of Orthopedic Surgery, Mayo Clinic, Jacksonville, FL and Jaiyoung Ryu, MD, Professor & Chief of Upper Extremity Surgery, West Virginia University, Morgantown, WV, and hand therapist Julianne Howell, PT, MS, CHT, private practice, Corvallis, OR.

Dr. Bednar: Let’s discuss ulnar-sided wrist pain, a common chief complaint of patients in every hand surgeon’s practice.

Let’s begin with the initial patient evaluation. What information do you consider important in the diagnosis and treatment of these patients?

Dr. Ryu: I think the most important question is, “Is there anything that makes your symptoms better, and anything that makes it worse.” Listening and envisioning those activities—for example, what kinds of wrist and forearm motion are demanded by these activities—helps me in terms of getting the correct diagnosis. If certain activities make the pain worse, then knowing the characteristics of the pain and how long the pain persists after the activity also helps. Finally, knowing how the pain responds to heat or cold, and rest or splint, helps me as well.

Dr. Murray: I like to focus on the mechanism of injury, but clearly there’s a large number of patients that present without any history of acute injury and there may be an attritional problem. In those that have a discrete injury, invariably it’s a twisting injury or a torquing type injury against resistance.

Dr. Bednar: Ms. Howell do you have any comments with regards to history? Most of my patients seem to confide more in my therapists than they do in me.

Ms. Howell: Fairly often wrist-injured patients are referred to therapy from primary care, urgent care or emergency room providers as an intermediary step to consultation with a hand surgeon. As a result, I have found that besides knowing the mechanism of injury I must establish a baseline of data that I can repeat later to assess the outcome of my treatment intervention. For me, this baseline data includes a patient sketch of their symptoms at-rest and with-use, documentation of pain restricted or excessive wrist and forearm motion; areas of palpation tenderness, and response to provocative maneuvers. This baseline data guides my future clinical decisions on whether to initiate or continue therapy verses recommending that the patient be sent for a hand surgery consult.

Dr. Bednar: Terrific. Do you have any specific physical exam maneuvers that you find more sensitive or more diagnostic?

Dr. Murray: I go through the gambit of physical examination maneuvers but the things that I concentrate on are first of all areas of tenderness. I’ve found that with triangular fibrocartilage (TFC) pathology, the TFC is generally tender. Either dorsally or in what Dick Berger has described as the foveal area, which is volar ulnar aspect of the wrist where there’s a depression just ulnar to the ECU. He refers to tenderness in this area as the “foveal sign.” I also put emphasis on pain with supination or hyper supination, and pain with ulnar sided loading of the wrist. Generally if there’s 2 or more of those findings positive I feel confident that the pathology is in the triangular fibrocartilage complex (TFCC), which includes the associated ligaments.

Dr. Bednar: Great. Dr. Ryu, do you have any comments with regards to physical findings for the other potential injured structures around the ulnar side of the wrist aside from the TFCC?

Dr. Ryu: Sure. First, I would like to emphasize the correct examination position, which is the patient sitting down in front of you with elbows resting on the table. Examining the opposite side first or at the same time as the affected side is important. Either dorsally or in what I refer to as the “foveal sign” I also put emphasis on pain with supination or hyper supination, and pain with ulnar sided loading of the wrist. Generally if there’s 2 or more of those findings positive I feel confident that the pathology is in the triangular fibrocartilage complex (TFCC), which includes the associated ligaments.

Dr. Bednar: Sure. First, I would like to emphasize the correct examination position, which is the patient sitting down in front of you with elbows resting on the table. Examining the opposite side first or at the same time as the affected side is important. I first go through passive pronosupination by holding the forearms. Examinating the opposite side first or at the same time as the affected side is important. I first go through passive pronosupination by holding the forearms. If this is full and completely painless, I can think more of ulnocarpal or intercarpal pathology rather than TFCC or DRUJ problems. As Dr. Murray says, I then go through the gambit of the maneuvers and all that, but I think one of the

YOU HAVE TO TREAT THE TISSUE THAT HAS BEEN SHRUNK JUST LIKE A FLEXOR TENDON REPAIR OR ANY OTHER FORMAL LIGAMENT REPAIR.

JOHN BEDNAR, MD
most important things is asking the patient where it hurts the most. I actually give patients a small marker or ballpoint pen and ask them to point to where it hurts the most, and that is usually where the pathology is. If the patients still have a hard time pinpointing the pain, I ask them to mimic activities which make their wrist hurt and locate the painful area that way.

Dr. Bednar: Having gone through the history and the physical exam, what objective studies do you find useful?

Dr. Murray: I will always get an x-ray of the wrist. Our musculoskeletal radiologists are quite good at diagnosing TFCC pathology using the 3T MRI. This magnet produces extraordinary imagery of the TFCC. Having said all that, I usually will be fairly aggressive about scoping these patients and just bypass that rather expensive testing.

Dr. Bednar: Dr. Ryu, would you still obtain an arthrogram in this day and age?

Dr. Ryu: No, I rarely use arthrogram, bone scan, or ultrasound. Most of the patients I see with chronic wrist pain come with some expensive test already done, especially MRI nowadays. Unfortunately, they are not necessarily high resolution MRI’s, and probably without a designated wrist coil, and really don’t help very much. I do use CT when I suspect radioulnar arthrosis or instabilities. Like Peter, arthroscopy is pretty much the gold standard for me in making the final diagnosis.

Dr. Bednar: So if your history and physical suggest the TFC injury would you operate in the face of a negative MRI?

Dr. Ryu: Absolutely.

Dr. Bednar: Dr. Murray?

Dr. Murray: Yes, I would.

Dr. Bednar: Is there a role for non-operative treatment in someone who has an acute twisting injury to the wrist, has physical findings consistent with some ulnar sided ligament pathology but no carpal malalignment?

Dr. Ryu: In my practice, immobilization of the wrist, usually in a Munster cast, for 4 to 6 weeks is the norm for patients with acute symptoms or recent history of injury.

Dr. Murray: I agree with Dr. Ryu. I see a good number of children and adolescents and I’m fairly optimistic that some of them can heal if immobilized. I usually don’t immobilize them more than 3 to 4 weeks, but I’ll give it a go if I catch it early. If I catch it late then I’m not as optimistic.

Dr. Bednar: Ms. Howell, what type of splint would you recommend for these type of patients, particularly with the ulnar sided wrist pathology?

Ms. Howell: Like most hand therapists I’m not sure I have just one favorite splint! What I’m after is a splint that preferably eliminates or reduces the patient’s symptoms. This is where the collection of baseline measures taken originally guides me in the choice of splint. If for example, forearm rotation is painful, I will need to start with a posterior Muenster splint to eliminate pronation/supination. In the case where pronation and supination are fine but extension and ulnar deviation are painful I will fabricate a custom short wrist splint into which I boost the ulnar-side of the wrist under the pisiform. I decide to use this splint when during my exam boosting the piso-triquetrum unit dorsally reduces their symptoms. Because this splint is short it will allow a jog of controlled wrist movement. This same splint can be made longer in the more acute patient and shortened as symptoms resolve. I hope that by 3 weeks into treatment that we are seeing the baseline measures improving so that the splint can be altered for less support, and controlled range of motion out of the splint can be added. If by 4-6 weeks the patient cannot progress into controlled loading exercises without exacerbation of their symptoms then I suggest that a hand surgeon be consulted.

Dr. Bednar: Dr. Charles Melone has described a spectrum of injury to the ulnar side of the wrist, starting with a triangular fibrocartilage injury and then progressing to detach the ECU sub-sheath, the ulna-carpal ligaments, LT ligament and eventually the dorsal-radial carpal ligament, completely destabilizing the ulnar aspect of the wrist. Is this spectrum something that you see in your clinical practice? If so, when you perform arthroscopy to treat a TFC injury, do you then look to the next level to the ECU, to the LT ligaments? And if they are injured do you consider treating them?

Dr. Ryu: I can’t say that I see that spectrum routinely in my practice. Yes, I do look for other pathologies when we examine or scope a wrist, and yes, I do find different combinations of pathologies here and there, but no, I do not see that whole spectrum on a routine basis in my practice.

Dr. Murray: I agree, I will occasionally see LT pathology or ulnar leash ligament pathology but I haven’t been that impressed that it is related to a spectrum, or maybe, as Dr. Ryu has mentioned, I haven’t looked for it hard enough.
Dr. Bednar: Well let’s move on to talk about some specific injuries. The Palmer 1B peripheral tear of the TFC, is one of the more common TFC injuries I see. What’s your preferred method for treatment?

Dr. Murray: Well if it’s a 1B with a styloid detachment or a styloid non-union, I’ll try to get bone to bone fixation if possible. If it’s a 1B without a styloid fracture or just a pure peripheral tear then I usually try to repair that arthroscopically and with an outside-in arthroscopic technique. I immobilize the patient in a Munster-type splint for approximately 3 to 4 weeks and then start motion.

Dr. Bednar: How do you decide to whether or not you can save the ulnar styloid fragment? If you can’t save it what do you do?

Dr. Murray: If I can’t save the boney fragment I’ll just repair the peripheral TFCC attachment.

Dr. Bednar: Some of the tears we call 1B tears may not be completely detached from the styloid, but are more of a detachment from the ECU sub sheath and the dorsal aspect. Do you treat those any differently?

Dr. Ryu: Yes, for a partial tear without DRUJ subluxation and no sign of instability, I will simply debride the tear. Dr. Bednar, how often do you see those 1B tears?

Dr. Bednar: I see probably a dozen a year with that injury. They don’t have a fracture, but have some laxity of the distal ulnar joint. When you scope them you see that there’s a detachment from the peripheral TFC along the whole dorsal aspect up to the styloid. If you really probe the TFCC insertion, the ligamentum subcutatum appears to be intact, but the more superficial fibers are disrupted. Those are the ones that I’ve been repairing. If there’s a tear just along the periphery and the entire attachment to the ulnar styloid is intact then I would agree, I would just debride those.

Dr. Ryu: Do you use shrinkage after you debride them? We all know that it failed pretty badly in the shoulders and knees. But, I have a feeling that the main reason the shrinkage failed in these areas is because we don’t have a very good immobilization technique for those joints. The wrist is different in that it can be effectively immobilized with a cast. I’m wondering if we can expect better results with shrinkage techniques in the wrist.

Dr. Bednar: If you look at the process by which the shrinkage works, it’s denaturing the collagen in the structures you are shrinking. You have to make sure that you don’t shrink the entire structure. Ideally you’re supposed to shrink in a checkerboard pattern, which is sometimes hard to do in these small structures. And you’re correct, you have to treat the tissue that has been shrunk just like a flexor tendon repair or any other formal ligament repair. You need to immobilize it for at least 6 weeks. Most of the time when patients start moving early they’re going to fail due to ligament rupture because of exactly what Dr. Ryu is commenting about. With the shrinkage process, you’ve made the structure actually weaker for the first 10 days to 3 weeks and it doesn’t return to full strength until 6 weeks.

Dr. Ryu: When I see a less than perfect trampoline effect during arthroscopic examination, I do use shrinkage for the reasons I just mentioned, regardless of what type of tear it is. It is and will be very hard to scientifically prove it, but I think it works for my patients.

Dr. Bednar: I’ve actually had better success with partial tear or stretched intercarpal ligaments like the scapho-lunate intercarpal ligament.

Dr. Ryu: I use shrinkage for them too.

Dr. Bednar: Where it’s loose and lax but not completely disrupted (in that case doing some capsular shrinkage, plus or minus), pinning the structure for 6 weeks has been more rewarding.

Ms. Howell: I would like to go back to the protocols and address some therapy concerns. I think it’s imperative that the therapists either talk with the surgeon directly or get the operative note to see how extensive the injury was and what procedure was done, and tailor individual rehab programs depending on those. Our general guideline for TFC repairs post-op is to start with a posterior Munster splint that limits forearm rotation and wrist motion. Depending on what the surgeon has done and what the surgeon and therapist have discussed, forearm rotation is begun anywhere between 4 to 6 weeks, and the program advances thereafter. Patients who have had debridement remain splinted for 4 weeks and those with a repair for 6 weeks. Controlled Dart-thrower and forearm motion starts at that time for each respective group. But if the therapy program is making them symptomatic, you’ve got to back off. This is especially true as you get past week 6, when you want to start adding some resistance, such as progressive gripping and loading through the palm of the hand/wrist. My hope is that by week 8 to 12, depending on the severity of the procedure, the patient is moving on away from therapy.

Dr. Murray: When would you let a high performance athlete or laborer go back to maximum lift/maxim-
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.

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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.

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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.

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mum grip activity after a 1B peripheral tear repair?

Dr. Bednar: When I see these patients, as part of the pre-operative discussion I tell them it’s probably going to be 3 to 4 months, if everything goes well. And certainly I would go by what the therapist is telling me in terms of how they’re responding to their resistive strengthening protocol, what kind of motion they get back, and what their grip strength is. Assuming everything goes well, 3 months at the earliest, but it may take 4, or sometimes even 5 months before it is possible to return to heavy labor or competitive sports.

Dr. Ryu: The only exception I may make is when a player might lose a career-changing opportunity. For example, I sometimes let a football player practice and play with his wrist in a cast, if the game can be a determining factor in his professional career.

Dr. Murray: I tend to be pretty conservative. I don’t treat as many middle-aged or young adult laborers, but sometimes I’ll wait 4 to 6 months before I say you can go bench press 250 pounds or something of that nature.

Ms. Howell: Using this example of bench pressing, I would want to continue to encourage smart wrist loading. Maybe we could come up with an alternative exercise, but finding a substitute for bench pressing is tough. I think the best message to the patient is to let them know that they’re going to be really challenging that wrist and that repair and they’re not going to be happy down the road. For many patients, just being able to bear their own weight for a modified push up is difficult at 3 to 4 months.
**Dr. Bednar:** One thing that we haven’t discussed as we’ve been going through this process is the dorsal ulnar sensory nerve. Some patients, in addition to the TFC pathology, will complain of a burning, numbness or a tingling and can sometimes even have ongoing neuritic symptoms well after the surgical process has run its course. Does anybody have any comments with regards to the nerve? Would you operate on someone who pre-operatively has an irritated nerve and are there any tricks to avoid injuring it when we’re doing the surgery?

**Dr. Ryu:** I use an outside in technique for 1B repairs not only because think I can put the torn TFCC back to the fovea a little more accurately, but also because I have a better chance in avoiding damage to the sensory branches.

**Dr. Bednar:** Ms. Howell, do you have any suggestions for treating that nerve when it gets irritated?

**Ms. Howell:** Initiating surgery-safe controlled motion of the fingers and wrist and scar massage will reduce adherence of the nerve to the surgical scar. Problems like this speak to the importance of the hand surgeon and hand therapist working closely. To make a difference with this nerve the therapist should be involved within the first 10-14 days after surgery. When discovered early, the nerve and the scar are more favorable to change. If the nerve and scar are left under the postoperative cast for 4-6 weeks, it will adhere and be sensitive to touch. When range of motion is then added, this adversely pulls more on the stuck nerve causing neurogenic pain. Earlier we talked about the role of non-operative treatment; I think some of the pain had by patients with ulnar-sided wrist injuries is linked to the sensory branch of the ulnar nerve. Often once the nerve quiets the burning pain recedes. So I think a role for non-operative treatment is to get the nerve less painful before you operate, and be aware that it may be overly sensitive after surgery.

**Dr. Murray:** I haven’t found non-operative measures or temporized measures to be very effective. I’ve had a pretty low threshold for just doing a neuroectomy and burying that nerve if it’s a problem. I have been reasonably satisfied with the results of that procedure, if the patient’s well aware of the sensory deficit that follows.

**Dr. Bednar:** What’s your favorite place to bury it?

**Dr. Murray:** I find a place to bury it in the ulna.

**Dr. Bednar:** Dr. Ryu you were talking, before we started the conference, about piso-triquetal problems.

**Dr. Ryu:** Yes, I think I’m seeing pisotriquetral arthritis as well as pisiform subluxing on triquetrum more often nowadays. It is usually easy to make a diagnosis with physical exam and special views, and you can confirm with a CT if necessary.

**Dr. Bednar:** What is your treatment?

**Dr. Ryu:** I make a formal incision and I use a beaver blade and shell it out.

**Dr. Murray:** One other pathologic condition I’d add to the discussion is the ECU tendonitis. We see a number of patients with this condition and occasionally the ECU tendon will be unstable and failure of its sub-sheath will lead to snapping subluxation. That’s always something to look out for in people that use heavy tools.

**Dr. Bednar:** What’s your surgical remedy for ECU subluxation?

**Dr. Murray:** Infrequently reconstruction of the sub-sheath is possible, but in most situations the ECU sub-sheath is in poor condition and it can’t be salvaged. Under those circumstances I will take an ulnarly based flap of the extensor retinaculum and make a sling and pass that beneath the ECU and then tie it to the remaining extensor retinaculum in order to stabilize the ECU.

**Dr. Bednar:** Dr. Ryu, do you have any other tricks for the ECU subluxing patient?

**Dr. Ryu:** In rheumatoid patients, I do a thorough tenosynovectomy followed by a radially based retinacular sling reconstruction. For traumatic cases in more active and younger patients, I use the same thing, a retinacular sling, if and only when conservative treatment failed.

**Dr. Bednar:** Ms. Howell, have you had any success with splinting these patients?

**Ms. Howell:** Some patients with pisotriquetral arthritis will respond to conservative management to eliminate weight-bearing on the pisiform, positioning the FCU on slack in a splint or with taping to move the joint out of the close-pack position. People who use a mouse or rest the heel of their hand on a firm surface while keyboarding often report pisotriquetral pain. So adjusting the ergonomics and adding a soft wrist rest are also important interventions. As for ECU tendonitis, it responds nicely to a wrist gauntlet splint that’s custom-made to boost the pisiform dorsally to unload the ECU. Clinically I believe the tendonitis or tendinopathy is a precursor to ECU subluxation later.

**Dr. Murray:** For ECU subluxation, I like to immobilize them in pronation. In supination the ECU takes more of an angular route from the lateral epicondyle to the base of the 5th metacarpal, so...
pronation puts the least amount of angular stress on the tendon.

**Ms. Howell:** A wrist splint with the wrist in radial deviation and forearm neutral works nicely too.

**Dr. Bednar:** Dr. Murray, do you think the ECU tendonitis is occurring because there has been sub-sheath injury and some imminent instability?

**Dr. Murray:** I don’t think it necessarily implies that it starts as a sub-sheath injury. ECU tendonitis can occur from attritional wear, and sometimes you’ll find osteophytes or rough surfaces about the groove of the ulna, or that the groove in the ulna is deficient. But almost always the sub-sheath fails in patients that have chronic ECU tendonitis and one of the questions that has always perplexed me is why they don’t all have ECU subluxation. I may be due to the size or the depth of the ulnar groove.

**Dr. Bednar:** Many of these patients for which you’re treating TFC pathology when you scope the mid-carpal joint you will see a disruption of the dorsal LT interosseous ligaments but an intact volar ligament. What is your treatment for that scenario?

**Dr. Ryu:** What you usually see is not an actual tear, but a little loosening, and from the midcarpal level you see a small gap with a hook between the two bones. For these cases, I go back to the radiocarpal joint and shrink them. If there is more instability without an actual tear, then I would pin the joint and shrink it. If there is visible tear, then that’s a different story. I usually pin it and repair the ligament, but it is rare as an isolated pathology.

**Dr. Murray:** I would try to probe the interval to see if its unstable, if it appears very unstable then I will pin it. If it’s a heavy laborer I have fused some of the LT joints, but in active individuals I haven’t been very happy with those results.

**Dr. Bednar:** Ms. Howell, do you have any tricks for the patients that have LT problems?

**Ms. Howell:** From a therapist’s standpoint my greatest fear in the patient with LT problems is that we move them too fast after surgery, and they become unstable again. In this group I tend to back off a little bit more, and allow them to get stiff and hopefully stay stable. Most of these patients want to be able to bear weight on their palm, load their wrist and grip without pain. And that’s where I think as a therapist I change my game plan from moving them right along to pulling in on the reins, slowing the effort to regain motion in favor of more stability.

**Dr. Bednar:** I have been doing pretty much what Dr. Ryu is talking about. If they are loose but not unstable I’ll debride some of the edges and do a capsular shrinkage. If it appears that they’re unstable and the volar component is also injured then I would pin them. In an occasional patient as you further explore them you can run an elevator from the midcarpal ulnar porthole along the whole dorsal aspect of the triquetrum, that tissue across the dorsal of the triquetrum is the attachment for the dorsal radial carpal and dorsal inner carpal ligament. If the patient has midcarpal instability on physical examination, I would also open and reattach the dorsal radial carpal ligament origin back to the triquetrum. But the vast majority of patients I would just be debriding and/or shrinking.

I would rather have a stable painless wrist than a wrist with a full range of painful motion. However, all of my patients want to know when they can do a push up.

**Ms. Howell:** My expectation with a TFC patient is that by 12 weeks they could do a modified push up, in a patient with an LT ligament tear I sometimes push that expectation to 4 months out.

**Dr. Bednar:** I would agree with you. Most of these ligament repair patients are more difficult and they’ll be more prone to stretching out any type of repair. Attempting to achieve a goal of normal full wrist motion may actually end up with recurrence of the instability symptoms.

**Dr. Murray:** In the acute distal radius fracture with an avulsion of the ulnar styloid at the fovea, when do you fix those styloid fractures, and when you do fix them what is your preferred technique?

**Dr. Bednar:** I have at this stage fixed all of those at the time when I do the volar plating or do the fixation of the radius. If it’s a large piece I’ll either do a tension band or on occasion a single small screw.

**Dr. Ryu:** I don’t like to use K wires or tension band because they often need to come out sooner or later. I try to use headless screws when possible. But, I find the DRUJ remains more often than not stable after good reduction and fixation of the distal radius fractures. After the distal radius fixation I examine the DRUJ for instability by shucking them and using Orbay’s pivot shift test. If I do not find instability, I leave the ulnar styloid fracture alone.

**Dr. Bednar:** If I’m going to immobilize my patients in a long arm cast and immobilize the radial ulnar joint it probably doesn’t matter, but in most cases when we fix the distal radius we want to get them into a short split and start early motion. Most patients choose to sit with their wrist and forearm in a pronated position. My concerns when I don’t fix the styloid is that while they may not be unstable on the table, 6 weeks
later after they’ve been sitting with their wrist in a pronated position with this dorsal directed force of the distal ulna pushing upward there is now all of a sudden just enough of a shift that some of these patients become lax and symptomatic. I’ve had less of a problem with that late instability by fixing the TFC at the time of the distal radial plating.

Dr. Murray: I go through the process of examining the ulna on one side and compare it to the other side. In most cases I will fix the avulsed fracture and I usually use a G2 anchor. I place the G2 anchor proximal to the fracture using a figure 8 loop of 2-0 Ethibond around the ulnar styloid through the fovea region, grabbing the TFCC and then tying it down on the shaft of the ulna.

Ms. Howell: The current trend after a distal radius ORIF is to use a short arm splint and get the wrist moving. However if you do these additional repairs, do you still use the short arm splint or do you put them in a posterior Munster splint? Perhaps we need to rethink our splint management of distal radius fractures.

Dr. Bednar: I usually have the therapist make a sugar tong splint.

Ms. Howell: Do you think, if you backed up and put them in a sugar tong splint, that that would eliminate the need for the repair?

Dr. Bednar: It’s a possibility. The patients that have a fracture through the tip of the ulnar styloid or a portion of the styloid that does not include the fovea, those don’t get fixed unless they are unstable. They do get treated with a sugar tong and I’ve been satisfied with the results.

Ms. Howell: There again, sometimes in our hurry to get moving after a distal radius fracture we forget the impact the injury may have had on the ulnar side of the

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**Director at Large**

**Steven McCabe, MD**

Steven McCabe is a newly elected board member for the AAHS. He is a long time member and frequent participant in the annual meeting. Dr. McCabe enjoys the AAHS because of the qualities embodied in the annual meeting and the relaxed, inclusive nature of the organization. Although a life long student of all things related to the hand, Steve’s interest has gravitated to the study of hand surgery from the perspective of the population. This has pointed him in the direction of carpal tunnel syndrome, an illness he claims to be the most fascinating upper extremity problem, and recently to studying economic aspects of hand surgery.

Steve was born in Loring, Ontario, Canada and grew up in the small farming community of Dresden, Ontario. He spent his first 16 years planning a career in the National Hockey League. In high school, he enjoyed mathematics and thought about pursuing engineering, but was advised by his high school counselor, hockey coach, and mother to be a doctor. He graduated with a medical degree in 1980 from the University of Toronto and finished residency training in Plastic and Reconstructive Surgery four years later at the University of Western Ontario under the guidance of the Chairman, Robert MacFarlane. At Western, he developed a love for Hand Surgery and further trained at the University of Toronto with Jim Murray and The University of Louisville, where he notes Harold Kleinert and Tsu Min Tsai were influential in his development. Returning as a faculty member to The University of Toronto for four years before moving back to Louisville to work at the Kleinert Institute and UofL, in 1992, he has divided his energy between academic pursuits and the clinical practice of hand surgery. While working in Toronto, Steve studied at McMaster University in Hamilton Ontario, receiving a Masters of Science degree in Clinical Epidemiology. This was the most important brick in the foundation of his academic life, something he claims to have undertaken at the suggestion of Ralph Manktelow. He credits this degree with changing his life and bringing clarity and focus to his aspirations. He currently practices hand surgery at Louisville Arm and Hand, has a clinical appointment in the Department of Orthopaedic Surgery, and is the Director of Decision Science at the School of Public Health and Information Sciences at the University of Louisville.

Teaching hand surgery fellows, residents, and graduate students has always been important and enjoyable to Steve. This year he was awarded the University’s Distinguished Teaching Medal for his efforts. He frequently teaches instructional courses in the areas of research methodology and the outcomes movement at national meetings. He is active in the ASSH and is a Past President of the ASPN.

Dr. McCabe lives in Louisville, KY with his family. His oldest daughter has recently graduated from Queen’s University and his two younger children, Robert, and Meghan are in high school in Louisville. His hobbies now include reading and writing, walking with his wife Janette, and playing the violin. He has recently retired from ice hockey, finishing his career in the men’s B league at Iceland Hockey Arena.
Gretchen Kaiser, OTR/L, MBA, CHT

Personal: I grew up in Royal Oak, Michigan and moved to Arizona in 1998. I met my husband, Leonard Bodell, in Phoenix and we were married in June 2006. We are expecting a baby boy in November 2007! In my free time I enjoy traveling, hiking, and reading.

Education: I graduated with a Bachelor’s degree in occupational therapy from Saginaw Valley State University in 1998. I earned my Master’s in Business Administration in 2003, and became a CHT in 2004. I am currently enrolled in the Doctorate program at Rocky Mountain University in the first CHT cohort anticipated to graduate in August 2007.

Employer: I currently work for Spooner Physical Therapy in Phoenix, Arizona. I developed and orchestrated the Hand Therapy Department at Spooner Physical Therapy and am currently the Director for three clinics.

AAHS Involvement: I am a member of AAHS.

Best Part of My Job: Seeing the true joy in people’s eyes as they see hope, and sharing their happiness as they feel better; the bonds I share with patients and my team members at work; being able to facilitate a positive work environment for the therapists on our team.

Major Accomplishments: Beginning my volunteer journey with the Guatemala Healing Hand Foundation- being a part of something so incredibly special and meaningful.

Another accomplishment that started my career was venturing out to Arizona without a job and only a dream and desire to find a job and be successful. In these terms I have succeeded, but as I have grown, my definition of success has changed along the way. I am happy, healthy, and full of passion. I am only just beginning a career and life full of accomplishments!

Clinical Specialties: Wrist injuries and multi-trauma patients.

Greatest Challenges: Oh so many! For work it would have to be continuing to run a hand therapy department in the face of lower reimbursement, more paperwork and red tape, and a state Medicaid program that doesn’t recognize Occupational Therapy services as a covered benefit. Some personal challenges for me are creating balance and being ok with the things I can not change.

Three Words That Describe Me: Loyal, sensitive, motivated.
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(continued on page 2)
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- The Code of Medical Ethics may be viewed online at www.ama-assn.org/ama/pub/category/2498.html.
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