The 2007 annual meeting of the American Association for Hand Surgery will be held at the Westin Rio Mar Beach Golf Resort and Spa in Puerto Rico from January 10 to 13, 2007. The theme is Hand Treasures of the Caribbean and promises the attendee an adventurer’s chest of clinical pearls, educational rubies, diamonds of friendship, and exciting nuggets of gold.

The program begins on Wednesday, January 10 with a specialty day program emphasizing the techniques that insure rapid recovery from hand and wrist injuries. The afternoon lets you rate your golf swing against a pro, take a bioskills course, and enjoy the amenities of the resort. Save your energy for the welcome reception that night.

Thursday, January 11, begins bright and early with six instructional courses, a panel on the Evolution of the Hand, chaired by Amy Ladd, MD and featuring noted anthropologist Mary Marzke, PhD and neurologist Frank Wilson, MD author of The Hand: How Its Use Shapes the Brain. Richard A. Berger, MD, PhD updates the state of wrist and hand prostheses. After free papers, the morning session concludes with the keynote speaker, Bob Jamison, ABC national and former White House correspondent. Following lunch, the learning opportunities continue with six more ICLs and an update on coding strategies by Daniel Nagle, MD.

Friday, January 12, continues the adventure with six more ICLs, dual free paper sessions, a panel challenging the experts on distal radius fracture cases, and two keynote lectures by Robert D. Beckenbaugh, MD and Eduardo Zancolli III, MD. The afternoon is dedicated to Peter Murray, MD’s popular Comprehensive Hand Surgery Review that updates every aspect of hand surgery. Friday evening is not to be missed. It begins with a performance by Richard Kogan, MD, a psychiatrist and concert pianist who analyzes the tortured creativity of Gershwin through his letters, medical problems, and music. Step directly from there into the AAHS dinner dance and party that would make the Pirates of the Caribbean jealous.

Saturday, January 13, is our collaborative program with the American Society for Reconstructive Microsurgery and the American Society for Peripheral Nerve. Panels include Upper Extremity Injury in Modern Warfare detailing the recent advances in caring for severe extremity wounds and a Brachial Plexus panel full of practical management tips and nerve transfer specifics. Richard Gelberman, MD will be the Presidents’ keynote speaker.

The afternoon golf tournament underlines the fact that outside your front door there are championship golf, tennis, multiple pools, and an ocean beach.

continued on page 3
How to Write a Scientific Paper

Over the past 25 years I have been involved with many manuscripts as an author, and even more as a reviewer. Based on this experience, I have developed some very definite opinions on what elements help to make a paper worth writing, and worth reading. Here are my “top ten” points about scientific writing. I hope that you find them useful (my point #1):

1. Have a point that’s worth making. Write about something that others can learn from. Write about something that you learned, and think would be helpful to others. How your last fifty patients did will probably not be on that list, even if you are the first to do hand-writing analysis after carpal tunnel release performed using your own very special patented handy dandy device. As a clinician reader, what I want to learn is when to operate, and when not to. Which operations work, and which ones don’t. Which special circumstances favor one choice over another. Things to look out for, so I can learn from your mistakes rather than repeating them. It is unlikely that I will get any of that from a series of cases, all done similarly, without any comparison group. Not that you shouldn’t monitor your own results, to see how consistent you are, and how your patients are doing. It’s just that such information helps you more than it helps me. If I want to learn the technique, I can get the video, or take the course.

Plan ahead. Once you get your idea, sit down and review the relevant literature. Then, plan your study. Hopefully, it will be a prospective one, so that you can decide in advance what the most relevant outcome measures will be, and figure out the best way to collect them.

Put it in writing before you begin. Write out your protocol, including introduction, hypothesis, and methods, with references, before you begin. This is not only the road map for your study; it is also in effect the first draft of your final manuscript.

Consult with a statistician. They can provide invaluable help on both methods and sample size. One of the reasons I have never done a study comparing outcomes of different methods of CMC arthroplasty is because each group would need to be at least 100 strong. Hard to do in a reasonable time frame, even in a large center.

Be clear and to the point. All the parts of the paper should fit together. If you are writing on the results of a procedure for carpal instability, there is no point filling the introduction or discussion with the history of wrist anatomy. A scientific journal is not an encyclopedia. Everything should tie to the take home message of your paper.

Style and grammar matter. A well-written paper is easier to read and to understand. Because of that, it is more likely to be viewed favorably by a reviewer. Each paragraph, for example, should have one and only one topic sentence. Short sentences are easier to read, and understand. Avoid jargon. I refer often to Strunk and White’s “The Elements of Style”. It helps.

Follow the directions. All journals (and granting agencies!) have instructions for authors, which include details about length, formatting of illustrations and references, and so forth. Follow them.

Nothing displeases an editor or reviewer more than having to mentally reformat an article in order to follow its flow, or to tease out its point.

If you are writing in a language in which you are not fluent, get help! I have written papers in English, German, French, Spanish, Italian, and Japanese. For all but the English ones, I got help from colleagues who spoke that language. I have done similarly in English for those for whom it is a second or third language. Far better to do this before submitting than to expect an editor or reviewer to do this for you.

Proofread before you submit. And please be sure that you have read, and cited, each reference correctly. Nothing is more off-putting to a reviewer than when it seems clear that the author did not read
some of the references cited at critical points in the development of the author’s thesis. Some journals now require authors to submit copies of the first page of every reference cited, as proof that the author at least glanced at the articles referred to. This is a good thing.

Be wary of claiming to be the first at anything. Frequently authors will make this claim, often based on a computer search of the English literature. But the computerized Medline database only goes back to 1966, and many foreign language journals are not included, even after that date. A truly comprehensive literature review would involve many databases, and is beyond the resources of most of us. Stick to reporting what you observed, what you learned, and why you thought it was important to share the findings with others. If it is helpful, it doesn’t matter if you were first or not.

A. Lee Osterman, MD
AAHS 2007 Program Chair

Jorge L. Orbay, MD
AAHS 2007 Program Co-Chair

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An Excellent Time to Go to Puerto Rico

It’s incredible that this year is coming to an end already. It has gone by so quickly. It seems like only yesterday that Sue Mackinnon handed me the gavel to take over as President of AAHS. Very soon, I will be passing that gavel onto the able hands of Brad Meland for his year as President. Very soon, many of us will be leaving for Puerto Rico for the Annual Meeting of AAHS at the Westin Rio Mar Beach Resort in Rio Grande, Puerto Rico, from January 10 to the 13th. Lee Osterman and Jorge Orbay have put together a great program. I am looking forward to the Specialty Day Program on Wednesday, January 10, that Aviva Wolff and Brian Adams have co-chaired, emphasizing the techniques that ensure rapid recovery from hand and wrist injuries. On Thursday, January 11, things begin very early with six instructional courses. Richard Berger is going to give us an update on wrist and hand joint replacement, a prosthetic update review. My brother-in-law, Bob Jamieson, who is ABC’s Senior National correspondent for Nightly News, will be the keynote speaker that day, explaining how journalists cover medicine, wars, and politics. A number of free papers will be available that afternoon. On Friday, we again return with a number of instructional courses. I have the opportunity of giving my Presidential Address and then I have the distinct pleasure of introducing my J. Joseph Danyo Presidential Invited Lecturer, Bob Beckenbaugh, who is going to address the issue of “Is It Fun Anymore?”

La Federacion del Mano Inaugural Meeting will be on

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Candidates for AAHS 2007 Officers and Board

President (automatic)
N. Bradly Meland, MD

President-Elect (automatic)
Scott Kozin, MD

Vice President
Nicholas Vedder, MD

Treasurer (1 year remaining)
Richard E. Brown, MD

Treasurer-Elect
Mark Baratz, MD

Secretary
Keith Brandt, MD

Historian
Matthew Concannon, MD

Senior Director
W.P. Andrew Lee, MD

Junior Director
James Chang, MD

Affiliate Directors
Rebecca von der Hyde

Nominating Committee
William Dzwierzynski, MD
Dean Sotereanos, MD

2007 PROGRAM

continued from page 1

When feeling less athletic, enjoy the world class spa, five gourmet restaurants, and casino. Close by, explore the natural beauty of El Yunque rain forest, visit the forts of Old San Juan, and salsa dance to the Latin nightlife. Thank you for being a part of this exciting, educational, and enjoyable experience.

A. Lee Osterman, MD
AAHS 2007 Program Chair

Jorge L. Orbay, MD
AAHS 2007 Program Co-Chair
There are three pools available to the guests. Championship golf, tennis and various other activities are also available. There are gourmet restaurants. I particularly liked the Italian restaurant. There is also a casino to enjoy. A new spa has opened, which is somewhat pricey, but available for your enjoyment. A number of optional tours and activities are being offered.

This will be my last AAHS Hand Surgery Quarterly report “From the President”. As I mentioned, in January, Dr. Brad Meland will take over to lead this organization for the next year. Our next annual meeting will be in Beverly Hills, California.

I look forward to seeing you all in Puerto Rico in January. I believe it will be a trip to remember and again, hope you bring your families. The future of our organization is bright and I am sure it will continue with the able leadership of our Board.

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FROM THE PRESIDENT

continued from page 3

January 10th between 1:00 and 5:00 pm. Eduardo Zancolli, as I understand it, is going to be one of the featured speakers. He will also serve on presentations at the AAHS meeting. This is something that I would not miss.

Friday is certainly going to be a busy day. In the afternoon, Peter Murray’s popular Comprehensive Hand Surgery Review Course will be given, updating every aspect of hand surgery. Friday evening is also going to be particularly special. We have had trouble fitting in all of the events that we had planned. Richard Kogan MD, a psychiatrist and concert pianist who analyzes the tortured creativity of Gershwin through letters, medical problems and music, is presenting an outstanding program that you and all of your family are invited to. Following that will be the AAHS dinner dance, for which we have an outstanding band and entertainment lined up, for everyone’s enjoyment.

Saturday is our collaborative program with ASRM and ASPN. The panels include Upper Extremity Injuries in Modern Warfare, which review recent advances in caring for severe extremity wounds. Another panel on Brachial Plexus will be full of management tips and advice on nerve transfers. Richard Gelberman will be giving the President’s Keynote Speaker address that day. Saturday afternoon will be our annual golf tournament. I haven’t had the opportunity of playing the golf course yet, but I can tell you it looks spectacular.

Hopefully, you will bring your families, as this is a great resort for the entire family to enjoy. The beach is right outside the doors of the hotel and is beautifully maintained. My wife made me spend one afternoon lying on the beach drinking piña coladas. It was such a chore!

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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

Michael Neumeister, MD
American Association for Hand Surgery
20 North Michigan, Suite 700
Chicago, IL 60602
The topic for this edition of *Hand Surgery Quarterly* is tumors. The following material will summarize coding for tumor related procedures.

While ganglion removal may not be exactly what comes to mind when considering tumors, ganglion surgery is quite common and relates to “excision of a mass.” Surgery for this procedure is generally coded according to where the ganglion is located. For the most common area, the wrist, removal of a dorsal or volar ganglion corresponds to code 25111. Note that for a recurrent ganglion, code 25112 would apply. Excision of ganglions that occur in the finger (mucous cyst or a ganglion of the tendon sheath) are coded with 26160. Excision of a non-ganglion lesion of tendon sheath in the wrist or forearm corresponds to 25110.

Excision of a soft tissue mass has a distinct family of codes, again subdivided by anatomical location. For excision of a mass that is subcutaneous, code 26115 is appropriate. For a deeper mass (subfascial or intramuscular), code 26116 is correct.

Radical resection of a malignant soft tissue tumor is coded with 26117. For masses in the wrist and forearm, code 25075 corresponds to a superficial location, and code 25076 corresponds to excision of a mass in a deep (subfascial or submuscular) location. Radical resection of a wrist or forearm mass is coded with 25077. Excision of a mass of the elbow or upper arm is coded with 24075 if the lesion is subcutaneous, and 24076 is the mass is deep. For radical excision of a malignant tumor of the elbow or upper arm, 24077 is appropriate.

Bone involvement for tumor surgery corresponds to a different set of codes. Curettage of a benign lesion in the metacarpal is coded with 26200; with autograft, 26205. For a similar lesion in the phalangeal bones, 26210 is appropriate (with autograft, 26215). Radical resection of a metacarpal for tumor corresponds to 26250 (26255 with autograft), and radial resection for a proximal or middle phalangeal lesion is coded with 26260 (with autograft, 26261). For a tumor in the distal phalanx requiring radical resection, 26262 is the appropriate code.

Curettage of a benign carpal bone tumor is coded with 25130 (with autograft, 25135; with allograft, 25136). Excision of a benign lesion the radius or ulna (shaft or distal area) is coded with 25120 (with autograft 25125; with allograft 25126). Radial resection of the radius or ulna for tumor is coded with 25170. Code 24110 corresponds to excision on a benign...
Sharon Dest, PT, CHT

Personal: I’ve lived and worked in Connecticut my entire life. I have two wonderful teenage daughters, Kerry, 18, and Erin, 13, with whom I have a very close relationship. One of the many things we enjoy doing together is going camping. When there’s time, I enjoy music, theater, photography and socializing, and making homemade jams and baking for the holidays. I’m actively involved with the Guatemala Healing Hands Foundation and their annual medical/teaching missions. This summer, my daughters joined me on a two-week medical mission and helped with fundraising beforehand. I especially enjoy meeting new people and going to new places, and I thrive on learning. My not-too-deep, dark secret is my weakness for unique jewelry. Whenever I come home from a trip, my friends always ask what piece I bought “this time”!

Education: I received my BS in physical therapy in 1980 from the University of Connecticut, completing my honors thesis on Evaluation of the Hand. I worked primarily as an orthopedic and sports medicine therapist for many years, and served as the “back up” to the primary hand therapist in our office. In 1999, I completed the Hand and Upper Extremity Fellowship at Texas Woman’s University in Houston. I went on to get my CHT that same year. I have been accepted into Rocky Mountain University of Health Profession’s DPT program with a concentration in Hand Therapy, with start deferred until their program accreditation is completed.

Employer: I work for HealthSouth at a management contract with Orthopaedic Specialty Group in Fairfield, CT. My caseload is primarily orthopedic hand and UE rehab but I still help out in the “gym” with other orthopedic patients when needed. At present I’m responsible for overseeing the hand program at OSG’s three offices and mentoring our junior hand therapists.

AAHS Involvement: Affiliate member since 2003. I was attracted to the Association by the fact that it promotes the idea of therapists and physicians working together. The part of the meetings I most enjoy is interacting with so many different people and hearing their varying perspectives on things.

Best Part of My Job: Patient care is still my first love. Developing a relationship with patients where they trust you with their wellbeing and are confident in the care you’re providing them is especially gratifying. I enjoy the constant intellectual and creative challenges of addressing each patient’s unique needs.


Clinical Specialties: Orthopedic UE injuries. This includes CTDs, fracture management, tendon repairs, and joint replacements. I love to splint!

Greatest Patient Challenge: The negative non-compliant patient. My challenge is to get them to take ownership of their therapy and not expect me to “perform a miracle” in the office. Also I try to refocus their energy and attitude to that of moving ahead toward recovery, not fixating on analyzing every nuance of their present level of injury or disability.

Three Words That Describe Me: Creative, optimistic, dependable.
tumor of the humerus (with autograft, 24115; with allograft, 24116). For benign lesions of the olecranon or proximal radius, code 24120 is appropriate (24125 with autograft; 24126 with allograft). For radial resection of a tumor of the humerus shaft or distal humerus, code 24150 is appropriate (with autograft, 24151). For radical resection of a tumor to the radial head or neck, 24152 is the correct code (24153 for use of autograft).

**You Code It**

A 46-year-old female presents for excision of a ganglion on her volar wrist. She had the lesion removed five years ago but it returned last year.

Solution: Code 25112

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**Soft Tissue Masses**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>26115</td>
<td>Excision, tumor or vascular malformation, soft tissue of hand or finger; subcutaneous</td>
</tr>
<tr>
<td>26116</td>
<td>Excision, tumor or vascular malformation, soft tissue of hand or finger; deep (subfascial or submuscular)</td>
</tr>
<tr>
<td>26117</td>
<td>Radical resection of tumor (e.g. malignant neoplasm), soft tissue of hand or finger</td>
</tr>
<tr>
<td>25075</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area; subcutaneous</td>
</tr>
<tr>
<td>25076</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area; deep (subfascial or submuscular)</td>
</tr>
<tr>
<td>25077</td>
<td>Radical resection of tumor (e.g. malignant neoplasm), soft tissue of forearm and/or wrist area</td>
</tr>
<tr>
<td>24075</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area; subcutaneous</td>
</tr>
<tr>
<td>24076</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area; deep (subfascial or submuscular)</td>
</tr>
<tr>
<td>24077</td>
<td>Radical resection of tumor (e.g. malignant neoplasm), soft tissue of upper arm or elbow area</td>
</tr>
</tbody>
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**Collaboration in the Caribbean**

One of my responsibilities as the Junior Affiliate Director on the AAHS Board of Directors is the Hand Therapy and Affiliate Member Corner of the newsletter and I am always a little overwhelmed with the task. Today, as I think of the AAHS, I think of the annual meeting and how much I enjoy that meeting. It is one of the best educational meetings in hand surgery and therapy, in a beautiful resort and with wonderful social activities. How can you do better than that in January or in any month? The 2007 AAHS annual meeting is quickly approaching and so there are hotel and airline arrangements to be made and the registration to be completed. As I am sure that you all know, the theme of this year’s meeting is “Hand Treasures of the Caribbean,” and it will be held at the Westin Rio Mar Beach Resort in Puerto Rico. The program, both academic and social, looks fantastic and I hope that many of you are planning to attend. The program will begin on Wednesday January 10, 2007. You will not want to miss the Specialty Day on Rapid Recovery – The Fast Track, which has been coordinated by Aviva Wolf and Brian Adams. It promises to be an excellent educational experience!

The AAHS as an association provides the opportunity for collaboration between hand surgeons, hand therapists, medical specialists, other allied health professionals and scientists. Each with their unique perspective and willingness to share knowledge and to learn from each other. There is no other organization that I know of that works so well together to combine these multiple areas of expertise and in the words of the AAHS purpose “to foster and assure the highest quality of hand care through the education of hand surgeons, allied health care providers, and the public; the promotion of research; and communication with other professionals”. I think that as an organization we do this very well through our annual meeting, educational courses, newsletter and most recently our journal, Hand. Over the years, the leadership of the AAHS has worked diligently to meet the needs of the AAHS membership and we have been privileged to have outstanding individuals volunteer to lead our organization. The strength of the AAHS lies in the membership and I encourage you all to support the AAHS in very small but concrete ways—through your support of the journal, attendance at the annual meeting and recruitment of new members. The information for the journal Hand, the annual meeting and membership can all be found at www.handsurgery.org, the AAHS Web site. We can all make a difference in our patients, in our profession and in the AAHS.

It will be January soon and I hope that we will all meet in Puerto Rico for what promises to be a fantastic educational experience. There will be ample opportunity to enjoy the beautiful venue at the Westin Rio Mar and I hope that you will attend the AAHS annual meeting for four days of education and enjoyment. I look forward to seeing you in Puerto Rico!
AAHS 37th Annual Meeting
Program at a Glance
January 10-13, 2007
Westin Rio Mar Beach Resort, Rio Grande, Puerto Rico

AAHS
Wednesday, January 10, 2007

6:30–7:30am Continental Breakfast with Exhibitors

7:30am–1:00pm Specialty Day Program: Rapid Recovery–The Fast Track

7:30–7:35am President’s Welcome
Ronald Palmer, MD

7:35–7:45am Overview – “When Can Recovery be Rapid?”
Program Chairs:
Brian Adams, MD
Aviva Wolff, OTR/L, CHT

7:45–8:00am Outcomes – How Do We Measure Rapid Recovery?
Joy MacDermid, PT, PhD, CHT

8:00–9:10am Wrist Injuries – “The Express Line”
Moderator: Christine Novak, PT

8:00–9:10am Scaphoid Fractures
Randall Culp, MD

8:10–8:20am Distal Radial Fractures
Jorge Orbay, MD

8:20–8:35am Recovery after Wrist Fractures
Dorit H. Aaron, MA, OTR/L, CHT

8:35–8:55am Ligament Injuries
Richard Berger, MD, PhD
Julianne W. Howell, OTR/L, CHT

8:55–9:10am Panel/Discussion

9:10–10:45am Digital Injuries – “Hold Fast”
Moderator: Brian Adams, MD

9:10–9:30am Metacarpal and Phalangeal Fractures
Michael Bednar, MD
Terri Skirven, MS, OTR/L, CHT

9:30–9:50am PIP Fracture Dislocations
Joseph Slade, MD
Paul Brach, MS, PT, CHT

9:50–10:10am Extensor Tendon Injuries
Brian Adams, MD
Julianne W. Howell, MS, PT, CHT

10:10–10:30am Flexor Tendon Injuries
Peter Amadio, MD
Rebecca von der Heyde, MS, OTR, CHT

10:30–10:45am Panel/Discussion
10:45–11:00am Break

11:00–11:20am Upper Extremity Fractures: Hand, Wrist and Forearm
Scott Kozin, MD
Dorit H. Aaron, MA, OTR/L, CHT

11:20–12:10pm Sports Injuries – “How the Athletes Do It in a NY Minute”
Moderator: Susan Michlovitz, PT, PhD, CHT

11:20–11:30am Surgical Treatment – When to Fix, When to Wait
Andrew Weiland, MD

11:30–11:40am Protective Gear – Rules, Regulations, Requirements
Michelle Carlson, MD

11:40–11:50am Methods of Protection – Splints, Padding...
Coleen Gately, MS, PT, DPT

11:50–12:00pm Casting Techniques for Sports Activities
Ronald Palmer, MD

12:00–12:10pm The Injured Golfer
Aviva Wolff, OTR/L, CHT

12:10–1:00pm Case Presentations – When Rapid Is Not So Rapid

12:10–12:20pm My Experience with Firefighters
Joy MacDermid, PT, PhD, CHT

12:20–12:30pm My Experience with the Not-So-Healthy Worker
Susan Michlovitz, PT, PhD, CHT

12:30–12:40pm Rapid Recovery and Nerve Injury, an Oxymoron?
Christine Novak, PT, MS, PhD(c)

12:40–1:00pm Panel/Discussion

1:00–1:30pm Rate Your Golf Swing Against the Pro

1:00–5:00pm La Federacion del Mano Inaugural Meeting
Eduardo Zancolli, III, MD
Course is complimentary but pre-registration is required.

3:30–5:30pm Bioskills Workshops
BW1 Current Techniques for PyroCarbonMCP/PIP/CM Arthroplasty
BW2 Current Techniques for DRUJ Disorder

6:00–7:00pm AAHS Welcome Reception
Thursday, January 11, 2007

6:30–7:30am Financial Instructional Course 101
Cost-Effective and Tax-Efficient Managed Money for Physicians
Patrick Donnelly, Smith Barney Consulting Group
Jeff Palmer, Smith Barney Consulting Group

7:00–8:00am Continental Breakfast with Exhibitors

7:30–8:30am Instructional Courses
102 The Treatment of Basal Joint Arthritis: More than Just Trapeziectomy
Matthew M. Tomaino, MD, Moderator
Alejandro Badia, MD
Randall W. Culp, MD
Eduardo Zancolli, III, MD

103 Treating Scapholunate Instability: A Gap Can Get You Into Trouble
Mel Rossenwasser, MD, Moderator
William Geissler, MD

104 Emerging Concepts in the Treatment of Common Tendonopathies
Wyndell Merritt, MD, Moderator
Julianne Howell, PT MS CHT
Nash Naum, MD

105 Solving the Failed Carpal/Cubital Tunnel Decompression
Susan Mackinnon, MD, Moderator
Christine Novak, PT MS Dean Sotereanos, MD
John Taras, MD

106 Improving the Outcome of Flexor Tendon Repair
Nicholas Vedder, MD, Moderator
Peter Amadio, MD
Randipsingh Bindra, MD
Michael Neumeister, MD

107 I Read It In The Journal. Should I Change My Practice?
Susan Micklewitz, PT, PhD, CHT, Moderator
Joy MacDermid, PhD, PT
Allen Van Beek, MD
Paul Vellman, PhD

8:30–8:40am President/Program Chair Welcome
Ronald Palmer, MD, AAHS President
A. Lee Osterman, MD, AAHS Program Chair
Jorge L. Orbuy, MD, AAHS Program Co-Chair

8:40–8:45am ASHH Presidential Welcome
David M. Lichtman, MD

8:45–9:45am Throwing Darts on the Back Nine: What Every Hand Surgeon Should Know about Evolution and the Skilled Human Hand
Amy Ladd, MD
Mary Marzke, PhD
Frank Wilson, MD

9:45–10:15am Wrist and Hand Joint Replacement: A Prosthetic Update
Richard A. Berger, MD, PhD

10:15–10:25am Presentation of 2006 Vargas Trip to Romania
Donna Pendleton, MS, PT, CHT
Lorna Ramos, MA, OTR

10:25–10:55pm Break with Exhibitors

10:55am–Concurrent Scientific Paper Session 1A
115 Resurrection of Dead Bone: Solving Kienboch’s and Avascular Non-Unions
T. Greg Sommerkamp, MD, Moderator
Kyle Bickel, MD, FACS
Steven L. Moran, MD

116 Pediatric Brachial Plexus Injury
Scott Kazin, MD, Moderator
Allau J. Belzberg, MD
Howard M. Clarke, MD

117 Adult Elbow Fractures
Mark Baratz, MD
Michael R. Hausman, MD
David Ring, MD

118 New Concepts in Total Wrist Replacement
William Cooney, III, MD, Moderator
Brian Adams, MD
Luis Scheker, MD

111 Reconstruction of the Burned Hand in Adults and Children
Roger Simpson, MD, Moderator
Bruce Brewer, MD

112 Surviving and Salvaging PIPJ Injuries
Robert Beckenbaugh, MD, Moderator
Scott G. Edwards, MD
Mark Rekant, MD
Teri Skirven, OTR/L, CHT

2:40–3:40pm Coding Alerts to Maximize the Work Unit Value

Friday, January 12, 2007

6:30–7:30am Financial Instructional Course for Non-Members

114 Financial Planning for the Newly Established Surgeon

7:00–7:30am Annual Business Meeting Breakfast

7:30–8:30am Instructional Courses
115 Resurrection of Dead Bone: Solving Kienboch’s and Avascular Non-Unions
T. Greg Sommerkamp, MD, Moderator
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continued on page 10
### Friday, January 12, 2007

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:30–8:30am</td>
<td>Instructional Courses (continued)</td>
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<tr>
<td>8:35–9:20am</td>
<td>Panel: Problem Solving in Distal Radius Fracture</td>
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<tr>
<td>9:00–11:00am</td>
<td>ASRM Strategic Planning Session</td>
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<tr>
<td>9:20–9:50am</td>
<td>Presidential Address</td>
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<td>9:50–10:25am</td>
<td>J. Joseph Danyo Presidential Invited Lecture: Robert D. Beckenbaugh, MD</td>
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<td>10:25–10:55am</td>
<td>Break with Exhibitors</td>
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<td>10:55am–12:30pm</td>
<td>Concurrent Scientific Paper Session 2A</td>
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<td>11:00am–1:00pm</td>
<td>ASRM Council Meeting</td>
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<tr>
<td>12:30–1:00pm</td>
<td>Hand Federation Presentation: Contributions and Influences of Argentina to Hand Surgery</td>
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<tr>
<td>1:00–6:15pm</td>
<td>Comprehensive Hand Surgery Review Course</td>
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### Saturday, January 13, 2007

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<td>6:30–7:30am</td>
<td>Continental Breakfast</td>
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<td>7:00–8:00am</td>
<td>Panel: Upper Extremity Injuries in Modern Warfare</td>
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<td>8:00–8:10am</td>
<td>AAHS/ASRM/ASPN Presidents Welcome</td>
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<td>8:10–9:10am</td>
<td>AAHS/ASRM/ASPN Presidents Invited Lecture: Richard H. Gelberman, MD</td>
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<td>9:10–9:30am</td>
<td>Break with Exhibitors</td>
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<td>10:30–11:30am</td>
<td>Outstanding Nerve Paper Presentations</td>
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<tr>
<td>12:30pm</td>
<td>11th Annual Day at the Links Golf Tournament</td>
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<tr>
<td>1:00–1:15pm</td>
<td>Tendonopathies and Dupuytrens Contracture</td>
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<td>1:15–1:35pm</td>
<td>Compressive Neuropathies &amp; CRPS</td>
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<td>1:35–2:00pm</td>
<td>Thumb Basal Joint Arthritis, Wrist Arthritis, Kienbock’s Disease</td>
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<tr>
<td>2:00–2:25pm</td>
<td>Inflammatory Arthritis of the Hand and Wrist</td>
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<td>2:25–2:45pm</td>
<td>Distal Radius Fractures</td>
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<td>2:45–2:55pm</td>
<td>Distal Radioulnar Joint</td>
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<tr>
<td>2:55–3:10pm</td>
<td>Scaphoid Fractures and Non-Unions</td>
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<td>3:10–3:30pm</td>
<td>Carpal Instability</td>
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<tr>
<td>3:30–3:45pm</td>
<td>Fractures of the Metacarpals and Phalanges</td>
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<tr>
<td>3:45–4:00pm</td>
<td>Flexor &amp; Extensor Tendon Injuries</td>
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<td>Infections of the Hand</td>
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<td>Congenital Hand Differences</td>
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<td>4:55–5:15pm</td>
<td>Tumors of the Hand and Wrist</td>
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<td>5:15–5:35pm</td>
<td>Soft Tissue Coverage in the Hands</td>
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<td>Tendon Transfers for the Hand X</td>
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<td>Vascular Disorders of the Hand / Reimplantation</td>
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<td>6:05–6:15pm</td>
<td>Questions / Adjourn</td>
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<tr>
<td>6:30–7:30pm</td>
<td>AAHS Invited Speaker: Richard Kogan, MD</td>
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<tr>
<td>7:30–11:00pm</td>
<td>AAHS Reception &amp; Awards Dinner Dance</td>
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</table>
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. Tomaino, MD, MBA

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

Distal Radius Fractures  
Peter J. L. Jebson, MD

Distal Radio-Ulnar Joint  
Brian O. 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. Rentree, MD

Flexor Tendon Injuries  
Kevin J. Rentree, MD

Infections of the Hand  
Kevin D. Blanchard, MD, MS, FACS, FAANS

Congenital Hand Differences  
Scott H. Kazim, MD

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

Peripheral Nerve Injury and Reconstruction  
Michael B. Wood, MD

Tendon Transfers  
Michael B. Wood, MD

Soft Tissue Coverage of the Hand  
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Tumors

One of the perks of attending the Annual Meetings is learning from the experts. This issue’s topic is moderated by one of AAHS’s Review Course presenters, Edward Athanasian, MD, Hospital for Special Surgery and Memorial Sloan-Kettering Cancer Center, New York, NY. Joining in the discussion are Peter Murray, MD, Mayo Clinic, Jacksonville, FL, Steven L. Moran, MD, Assistant Professor of Surgery, Division of Plastic and Hand Surgery, Division of Hand Surgery, The Mayo Clinic, Rochester, MN, and Susan Blackmore, MS, OTR/L, CHT, Philadelphia Hand Center, Philadelphia, PA.

Dr. Athanasian: The subject of this discussion will be enchondromas. This is a relatively common problem. It’s one that most hand surgeons will see on a regular basis. Each lesion has its own unique characteristics and unique problems. Dr. Murray, I’m going to call on you first. What are the types of clinical presentations you’ve seen of enchondromas in your practice?

Dr. Murray: I have a dichotomous practice in that I see a lot of children and a lot of elderly patients. The children with enchondromas are typically Ollier’s patients that have been referred to me from pediatric orthopedists. The other part of my practice is elderly patients. I don’t see a lot of enchondromas in the elderly; I’m not sure why, but consequently, I don’t see pathologic fractures through enchondromas in the elderly. So mostly I see enchondromas in the pediatric population and mostly in the setting of Ollier’s disease.

Dr. Athanasian: Dr. Moran, what are the types of presentation you’ve seen in your practice?

Dr. Moran: We see this presenting most commonly as an incidental finding on X-ray and occasionally as the cause of a pathological fracture in the proximal phalanx. We see very few patients with Ollier’s disease.

Dr. Athanasian: I’ve also seen the same types of presentation. The one additional presentation, and probably less common in my experience, is the occasional patient with a bone prominence or some specific tenderness over the metacarpal or the proximal phalanx. The X-ray then demonstrates the characteristics commonly seen with an enchondroma. Dr. Moran, What are the common plain X-ray findings you would expect to see in a patient with an enchondroma?

Dr. Moran: Classically these tumors have a lytic appearance within the bone with stippled calcifications. They tend to have well defined sclerotic borders and some cortical expansion. They are found most commonly in the proximal phalanx, followed by the metacarpal and middle phalanx. You have to differentiate this tumor form chondrosarcoma, fibrous dysplasia and giant cell tumor of bone.

Dr. Athanasian: Dr. Murray, you mentioned that you often see patients with Ollier’s disease. How do the X-ray findings in Ollier’s disease differ from that seen in a typical solitary enchondroma?

Dr. Murray: This is one of the things I should have mentioned earlier, that a lot of the Ollier’s patients that I see have deformity. There’s not only deformity, but also multiple lesions, which lead to the deformity. So there is simply more extensive involvement in patients with Ollier’s.

Dr. Athanasian: Dr. Murray, are there any X-ray features which you might see either in an Ollier’s patient or what appears to be a routine enchondroma that might raise concern about a more aggressive process?

Dr. Murray: I think the most disturbing to me is cortical destruction, and that usually is in the setting of a serial set of X-rays that have changed over time and particularly in patients, that have pain. So the constellation of cortical destruction in the setting of pain would give me the most concern.

Dr. Athanasian: Dr. Murray, it’s been said that Ollier’s can have a risk of malignant transformation somewhere between 10% and 30%, and that certainly will correlate with the extent of involvement. What clinical or radiographic findings would raise your concern that somebody might be developing a chondrosarcoma in the setting of Ollier’s disease?

Dr. Murray: A lesion with calcifications, greater cortical destruction, and with maybe an adjacent mass or soft tissue extension. Those would be the main things that I would concern me.

Dr. Athanasian: In the few that I’ve seen, patients will typically have had new onset or progressive pain in association with cortical destruct-
I prefer to have two complete surgical setups, and often I can have two separate surgical teams, so that there’s no cross contamination.

Peter Murray, MD

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sent to you with pathologic fracture. Do you favor intervening early or intervening after the fracture’s healed? And what are your criteria for choosing each course of treatment?

**Dr. Moran:** I prefer to intervene after the fracture has healed. If the fracture is unstable despite casting or has a significant angular deformity, you will need to put in K-wires; however, once the fracture is healed it is easier to completely remove the tumor which decreases the risk of recurrence.

**Dr. Athanasian:** If you’re going to operate within the first three weeks after the fracture, do you discuss the clinical setting with the pathologist? Do you warn him or her as to what they might be seeing that might confuse the picture underneath the microscope?

**Dr. Moran:** Absolutely. I try to avoid that because there can be a fair amount of confusion between identification of a callus, enchondroma, on chondrosarcoma on frozen section.

**Dr. Athanasian:** I tend to try to avoid operating early on. There is some literature which might suggest that there’s a better outcome longer term if you can get the fracture to heal and then go ahead and do the treatment. My indication for early intervention is deformity. Ms. Blackmore, when a patient has had a fracture through an enchondroma, they may be immobilized, perhaps for two to three weeks before range of motion is initiated. With a typical non-displaced proximal phalanx fracture in a middle aged person, how long do you anticipate it will take to regain full range of motion?

**Ms. Blackmore:** Three to four weeks. It depends on the length of time they were immobilized and any other conditions that may contribute to joint stiffness.

**Dr. Athanasian:** And how much of that time is supervised, as opposed to a patient doing their exercises on their own?

**Ms. Blackmore:** I primarily treat most of my patients on a home program basis if possible. The exercises for this problem are straightforward. Often I instruct the patient to provide manual support with their other hand at the proximal phalanx so there is external support at the fracture site. I have also made a cylinder splint to support the proximal phalanx to again provide support while performing exercises.

**Dr. Athanasian:** Ms. Blackmore, do you see earlier return of range of motion for metacarpal fractures?

**Ms. Blackmore:** Yes, I see that as an easier rehabilitation than I do the proximal phalanx unless there is significant angulation with the metacarpal fracture.

**Dr. Athanasian:** Dr. Murray, I’m going to ask you about which approach you favor for a typical proximal phalanx lesion. The classic approach described in most texts is the dorsal approach. What’s your favored approach and why?

**Dr. Murray:** I typically, for all phalangeal enchondromas, just make a dorsal approach, but I’ll go paramidline, either on the radial or ulnar side of the extensor mechanism to gain access to the phalanx itself. So I’ll make a dorsal incision and just then elevate the extensor mechanism entirely either one way or the other.

**Dr. Athanasian:** What do you think the advantages of a dorsal approach as opposed to a lateral approach?

**Dr. Murray:** I just prefer it for ease of removing the tumor. The midlateral approach, I think, gives you less access to the phalanx itself, and I think that through the dorsal approach and by elevating the extensor mechanism entirely you just get broader access to the phalanx.

**Dr. Athanasian:** I tend to favor a mid-lateral approach, assuming I can get reasonable access to the lesion. I absolutely agree, it’s easier to get exposure and access dorsally. My greatest concern with the dorsal approach is the potential for adhesion formation in the extensor mechanism. I have seen more rapid recovery with the midlateral approach, usually from the ulnar side if all is equal. The scar is well hidden. Dr. Moran, do you have a preference for your approach and why?

**Dr. Moran:** For smaller lesions I do prefer the midlateral approach. The bone is reached by splitting the lateral band or, occasionally for larger lesions, removing a portion of the lateral band. If it’s a very large lesion that’s close to the articular surface, I will then use a paramedian dorsal approach, which I feel does allow for better visualization.

**Dr. Athanasian:** Dr. Moran, do you have any tips for improving visualization and to ensure that the lesion’s been completely removed?

**Dr. Moran:** We use fluoroscopy intraoperatively to make sure that we’ve removed the lesion. We also use the K-wires or the small curettes within the lesion when we take our intraoperative imaging to determine the extent of the resection. Following what I feel to be a full resection of the tumor, I then take a high-speed burr and ground down a small portion of the inner cavity prior to placing bone graft.

**Dr. Athanasian:** There are some publications suggesting even using endoscopes to inspect the cavity after curettage. Dr. Moran… Dr. Murray, do you have any tips for how you might improve your visualization or how you ensure that the lesions completely removed?

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**STEVEN MORAN, MD**
Dr. Murray: Since the majority of the enchondroma patients I treat are children, I prefer autograft in my practice. For very, very large lesions I might use some allograft combination, but typically I use autograft.

Dr. Athanasian: What’s your preferred donor site?

Dr. Murray: Iliac crest.

Dr. Athanasian: Any concerns about cross contamination and how to avoid it?

Dr. Murray: Yes, certainly there is, but I’ve rarely seen a problem. I prefer to have two complete surgical setups, and often I can have two separate surgical teams, so that there’s no cross contamination.

Dr. Athanasian: Dr. Moran, what’s your preferred bone grafting material? Do you have any experience at all with bone substitutes?

Dr. Moran: I use cancellous chips and demineralized bone matrix. I have never seen any prospective randomized studies comparing autografts versus allograft. There are some reports of using nothing at all and simply replace the cortical window, but this delays healing time. Allograft decreases donor site morbidity and shortens tourniquet time.

Dr. Athanasian: Dr. Posner has done a retrospective study comparing autograft and allograft with similar outcomes. I tend to use allograft. I favor freeze dried or radiated allograft due to a lower risk of disease transmission. I have no experience using synthetic bone fillers. Is there any role for not filling the cavity if a patient refuses to consider grafting?

Dr. Moran: There are two studies that have looked at healing rates after simply replacing the cortical window, so it can be done; however if you chose this option I think that you have to warn the patient that healing time may be prolonged and splint wear may be prolonged.

Dr. Athanasian: Ms. Blackmore, we can spend all our time trying to scrape out bone cavities and fill them up with something and get a good looking X-ray, but really what will determine the clinical result is how the patient recovers their function and motion. For that patient who’s had a procedure on their proximal phalanx, no complications with wound healing, when do you feel comfortable initiating range of motion?

Ms. Blackmore: The timing for range of motion depends upon the stability of the bone and the potential for tendon adhesion formation. If the bone is stable, I suggest starting some degree of motion within the first week. It is extremely important to ensure the patient is achieving an active glide of the tendons, especially the extensor tendon. In the event the bone stability is less than...

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optimal, a short arc of motion under direct supervision of the hand therapist may be considered within the first two weeks.

Dr. Athanasian: Ms. Blackmore, what’s the role for protective splinting in these patients? And is this done continuously or only with specific activities?

Ms. Blackmore: I think protective splinting is important, certainly for the first four to five weeks. The patient removes the splint, to perform exercises to achieve maximum tendon excursion, extensibility and muscle-tendon unit length. And I do feel that protective splinting is important for sports related activities or for activities at work where contact force may occur. At a later date, one can consider using a circumferential splint just around the phalanx to protect from contact pressure or force.

Dr. Athanasian: Have you noticed a tendency for loss of range of motion at the proximal interphalangeal joint following procedures on the proximal phalanx in this setting?

Ms. Blackmore: Yes, I’d say that’s really the most difficult problem. In fact, often when I make a protective splint I will support the MP and proximal phalanx and leave the PIP free to move. However, if the patient cannot fully actively extend the PIP joint, this type of splint may leave the patient vulnerable to developing a PIP flexion contracture. In those cases I will intermittently splint the PIP in extension at night with a removable component to prevent the development of a flexion contracture. The fixed PIP flexion contracture can be one of the hardest things to resolve.

Dr. Athanasian: Dr. Moran, so many of these patients who have these problems are relatively young, and eager to get back to playing sports. How long do you wait before you let a patient return to a contact sport and what are the criteria for allowing them to return?
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<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>Richard Berger, MD, PhD</td>
<td><a href="mailto:berger.richard@mayo.edu">berger.richard@mayo.edu</a></td>
<td>Wrist surgery</td>
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<td>Mayo Clinic 507-284-4149</td>
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<td>Dupuytren’s; thumb reconstruction; flexor tendon surgery; trapezial excision arthroplasty; and medial epicondylectomy</td>
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<td>Kevin Chung, MD</td>
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<td>Rheumatoid and congenital</td>
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<td>E. Gene Deune, MD</td>
<td><a href="mailto:egdeune@jhmi.edu">egdeune@jhmi.edu</a></td>
<td>Congenital hand anomalies and upper and lower extremity reconstruction for deficits due to trauma, cancer resecation or neurological disorders (i.e. brachial plexus)</td>
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<td>Scott H. Kozin, MD</td>
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<td>Pediatrics</td>
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<tr>
<td>Don Lalonde, MD</td>
<td><a href="mailto:ddrdonlalonde@nb.aibn.com">ddrdonlalonde@nb.aibn.com</a></td>
<td>Wide awake approach to hand surgery</td>
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<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>
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<tr>
<td>William Lineaweaver, MD</td>
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<tr>
<td>Susan Mackinnon, MD</td>
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<td>Ulnar nerve surgery</td>
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<tr>
<td>Nash Naam, 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>
</tr>
<tr>
<td>Daniel J. Nagle, MD</td>
<td><a href="mailto:OOGIEN@aol.com">OOGIEN@aol.com</a></td>
<td>Wrist arthroscopy and endoscopic carpal tunnel release</td>
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<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 mentorship</td>
</tr>
<tr>
<td>A. Lee Osterman, MD</td>
<td><a href="mailto:loster51@bellaatlantic.net">loster51@bellaatlantic.net</a></td>
<td>Advanced wrist arthroscopy and small joint arthroscopy. Can also mentor a topic such as DRUJ problems, or wrist fracture.</td>
</tr>
<tr>
<td>Julian J. Pribaz, MD</td>
<td>Harvard Medical School 617-732-6390</td>
<td>Soft tissue reconstruction; microsurgical reconstruction; spare parts surgery and extremity reconstruction</td>
</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>Jaiyoung 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>
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<tr>
<td>David Slutsky, MD</td>
<td><a href="mailto:d-slutsky@msn.com">d-slutsky@msn.com</a></td>
<td>Wrist arthroscopy and arthroscopic repair of dorsal radiocarpal ligament tears; intra-articular distal radius fractures</td>
</tr>
<tr>
<td>Thomas Tung, MD</td>
<td><a href="mailto:tungt@wustl.edu">tungt@wustl.edu</a></td>
<td>Brachial plexus</td>
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<td>Joseph Upton, MD</td>
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<td>Congenital hand surgery</td>
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<tr>
<td>Elvin Zook, MD</td>
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<td>Fingertip reconstruction</td>
</tr>
</tbody>
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