After receiving the exciting news of being selected the recipient of this prestigious international hand therapy teaching award, my first thought was that I would need to do some research on Bulgaria to better prepare for my mission. A quick Google search showed that Bulgaria borders Turkey, Greece, Serbia, Romania and Macedonia. My next thought was to speak to Donna Pendleton PT, CHT and Lorna E. Ramos MA, OTR/L, both recipients of the 2006 Vargas Award who traveled to Cluj-Napoca, Romania as part of their mission. I was hoping their experiences and the similarities in the countries would shed some valuable insight and help to facilitate our mission.

What I soon learned from my research and conversations is that Bulgaria has a well-storied history, filed with long periods of war, communist control and political unrest. Going all the way back to 1000BC, Bulgaria faced continual warring for domination of the country by Romans, Turkish and then Russian occupation. Bulgaria survived WWI and WWII but unfortunately both times found itself on the losing side of those wars. The three world leaders, Roosevelt, Stalin and Churchill independently decided at the end of WWII to divide the Baltic States. Bulgaria was released from Communist control around November of 1989 which marks the fall of the Berlin Wall. Multi-party elections were held in Bulgaria and won by the communists who renamed the government the Bulgarian Socialist Party or BSP. Economic collapse and political instability soon eroded the Party’s authority. In the spring of 2001, the former King Simeon II, exiled to Spain since he was 9 years old, returned to Bulgaria. He re-entered the political arena and won by a landslide in the elections. The Bulgarian hopes were high that King Simeon’s return would unite the country. Unfortunately, it seemed that the only reason for Simeon’s return was to reclaim his wealth and possessions. His popularity plummeted after a few months in power. Since August 2005 new elections brought the BSP back into power with Sergi Stanishev as prime minister. In January 2007, Bulgaria and Romania officially joined the European Union. But the country’s history of government and historical issues certainly influenced how the Bulgarian Healthcare System is controlled and set the backdrop for our 2007 Vargas Mission.

As part of the 2007 Vargas Mission, an American-based team composed of myself along...
FROM THE EDITOR’S DESK

Join the AMA! It's Important!

In June of this year AAHS will have been seated in the AMA House of Delegates for five years. Given that AMA membership has fallen in recent years to roughly 300,000 members, or just 30% of America’s physicians, why is this important? Is AMA membership passé?

Far from it. AMA remains the only place where American physicians can speak for the profession as a whole, to advocate for patients in general, and to set policies generic to our profession. There is no other place where, with one voice, America’s medical profession can address such important issues as medical ethics, policies regarding healthcare reform, tort reform, recertification, scope of practice, Medicare reimbursement, specialty hospitals, and many other topics of relevance to us in our daily practice. The AMA motto is “together, we are stronger”. Never has that been more true, not its corollary-divided we are weaker. Indeed, one is reminded of Benjamin Franklin’s aphorism on witnessing the signing of the Declaration of Independence: “We must all hang together, or surely we will all hang separately”. Legal execution may be passe, but our profession is under threat from overregulation, poor reimbursement, and a tort system that is often out of control. There is no way to confront these issues individually, or even through individual professional societies. Those who do not wish us well will simply look for societies who differ in approach, pit one against the other, divide and conquer.

Why then is AMA membership dwindling? In many ways, the AMA has suffered from what has been called “the tragedy of the commons”. In earlier times, the village commons was a field own jointly by all, on which all animals of the villagers were entitled to graze. The problem of the commons is that it is free. Thus, each villager has an incentive to graze as many animals as possible upon it. Unfortunately, if everyone does that, the commons is soon depleted and no one can graze on it. This has happened in our own time with common fisheries: we eat Chilean sea bass (formerly called Patagonian toothfish) partly because it is tasty but mostly because the cod fishery collapsed, a consequence of over-fishing the oceanic commons.

The AMA is like a commons in that its benefits flow freely to all physicians, whether they are members or not. What are these benefits? Rules governing medical education, CME, hospital accreditation, procedure coding and professional ethics are just a few of the benefits that flow equally to all physicians, AMA member or not. Don’t like the policies of your specialty Board? Through AMA you have a voice- a third of each specialty board is appointed through AMA nominations? Ditto the Joint Commission that regulates our hospitals, and the residency review boards that govern our training programs. Legal protections for professionals, resolution of scope of practice issues, advocacy of legal protections to the doctor-patient relationship and many other safeguards we take for granted would not exist were it not for the AMA, and AMA advocacy. When federal regulations jeopardize our ability to care for our patients, only AMA can ask “Yes, but is it good medicine?” and be heard in Washington. When patient access to medical care is jeopardized, an organization like AAHS can do little by itself. Leveraged with 300,000 other physicians, though, meaningful healthcare reforms stand a chance.

This is not to say that AMA is perfect. There have been missteps certainly. It is embarrassing to all professionals when their parent organization appears to be self-serving, or appears to pander to the pecuniary interests of its members or officials. But these transgressions have never obscured the overall mission. American physicians have a right to be proud of the AMA and what it has accomplished over the last 150 years. Moreover, it remains, by default if for no other reason, the sole voice able to speak for all American physicians on the issues of fundamental importance outlined above. It is appropriate that AAHS sit in the AMA House of Delegates. Under new rules, specialty societies and state societies share authority equally, with each physician having in effect two voices- one geographic and one by specialization.
It is wholly appropriate that AAHS continue to do its share to keep up the AMA ‘commons’. You, too, can do your part. By becoming an AMA member you do your part in supporting the commons. By becoming active in AMA through our society representation, or through your state medical society, you further secure the benefits of the commons for future physicians. As professionals, we have a duty to look beyond our own self interest to that of our patients and of our vocation. The AMA remains the broadest expression of that duty, and I encourage all AAHS members to strongly consider their responsibilities in this regard. If you are an AMA member, thank you. If you are not, seriously consider becoming a member now. It will strengthen the AAHS voice at AMA and, more importantly, help assure that AMA remains a strong voice in defense of our patients, and our duties to them.

**EDITORS DESK continued**

**American Association for Hand Surgery Calendar**

**2008**

June 27–29, 2008  
AAHS Mid-Year Board of Directors Meeting  
The Ritz Carlton, Laguna Niguel  
DanaPoint, CA

September 18–20, 2008  
ASSH Annual Meeting  
Chicago, IL

October 23–26, 2008  
ASHT Annual Meeting  
Boston, MA

Oct. 31–Nov. 5, 2008  
ASPS Annual Meeting  
Chicago, IL

**2009**

January 7–10, 2009  
39th Annual Meeting  
Grand Wailea Resort  
Wailea, Maui, HI

Feb. 25–Mar. 1, 2009  
AAOS Annual Meeting  
Las Vegas, NV

September 2–5, 2009  
ASSH & ASHT Combined Annual Meeting  
San Francisco, CA

October 7–9, 2010  
ASSH Annual Meeting  
Boston, MA

October 23–29, 2009  
ASPS Annual Meeting  
Seattle, WA

**2010**

January 6–9, 2010  
40th Annual Meeting  
Boca Raton Resort & Beach Club  
Boca Raton, FL

October 1–6, 2010  
ASPS Annual Meeting  
Toronto, Canada

**2011**

January 12–15, 2011  
41st Annual Meeting  
The Ritz Carlton Cancun  
Cancun, Mexico

September 23–28, 2011  
ASPS Annual Meeting  
Denver, CO

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**Hand Surgery Quarterly**

Summer 2008

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The American Association for Hand Surgery continues to move forward. The Task Force designed to explore AAHS as a vehicle for Promoting Education in Developing/Emerging Hand Societies has made its first adventure overseas. Nash Naam is the Chairman of this committee and organized a course for the inaugural meeting of the Egyptian Hand Society. The meeting was held in March 2008. The meeting was attended by the following members: Ron Palmer, Allen Bishop, Brian Adams, Chris Novak, Jay Ryu, Mark Baratz, Nash Naam, Mike Neumeister, Peter Amadio, Rick Brown and myself. We expected a relatively small turnout, but over 300 people attended this inaugural meeting. The Egyptian Society for Surgery of the Hand was extremely grateful for the support of the AAHS. Dr. Naam will report more to the membership regarding this successful outreach effort.

Planning for the annual meeting in Maui, Hawaii is continuing forward. The course chairman are Miguel Pirela-Cruz and Becky Von der Hyde. They are working hard on the program as is the central office headed by Alice Romano. The meeting is January 7th -9th in Maui, Hawaii and abstracts are already being submitted. Deadline for submission is June 1, 2008. The meeting will provide ample time for education and camaraderie for all attendees. There will be a pre-course dedicated to Trauma and a variety of symposium/instructional course lectures.

The theme for the annual meeting is Volunteerism. Many of our members participate in volunteer efforts both within the United States and abroad. Their contributions will be highlighted throughout the meeting.

The AAHS Board is scheduled to meet at the end of June in California. There are a variety of task forces designed to increase the effectiveness of AAHS as an association and educational vendor. We have a full meeting schedule dealing with important issues that deal with your hand association, now and in the future. Following the Mid-Year Board Meeting I’ll provide a membership progress report and update. At the Mid-Year Board Meeting, the leaderships of American Society for Reconstructive Microsurgery (ASRM) and American Society for Peripheral Nerve Society (ASPN) will join with AAHS to further strengthen their relationship. This is the first time the three organizations have met together at the Mid-Year Board Meeting.

We are also meeting with the American Society for Surgery of the Hand (ASSH) to discuss ways to improve our efforts to enhance patient care and education. This face to face meeting is being held at the end of May in New York. Nick Vedder (President-elect), A. Lee Osterman (Vice-President) and I will attend and represent the AAHS. We have a packed agenda and look forward to further collaboration with ASSH in the future.

If you have any questions or concerns, please direct them to me or Alice Romano at the Central Office.

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Brian Adams, MD

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Mike Hayton, FRCS

Brachial Plexus Injuries
Randy Bindra, MD

Carpal Instability
Peter Armado, MD

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Marco Rizzo, MD

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Kevin J. Renfree, MD

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Kevin D. Plancher, MD, MS, FAICS, FAAOS

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Scott H. Rozin, MD

Tumors of the Hand and Wrist
Michael Bednar, MD

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Loree Kalfayan, MD

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with Dr. Jaiyoung Ryu traveled to Sofia, Bulgaria. Dr. Ryu has impeccable credentials as an Orthopedic Hand Surgeon and a Professor and Chief of Upper Extremity Surgery at West Virginia University. His accomplishments, publications and speaking engagements speak for themselves both nationally and internationally. He has dedicated many years to service as an ambassador of Hand Surgery and a committee volunteer for AAHS and other international hand organizations. Johanna Jacobsen-Petrov headed the Bulgarian team for the mission. Johanna, originally from Canada, is an Occupational Therapist who received her CHT in 1993 and worked throughout the USA as a traveling hand therapist. In 2000 she married Plamen Petrov and 7 years and three children later she now resides in Sofia, Bulgaria. It was at Johanna’s request to the AAHS that Bulgaria was chosen as the host country for the 2007 Vargas Award.

The Two Bulgarian physicians that would serve as our liasons were Dr. Boris Matev, who spent time in the USA working with Kleinert and Dr. Lyudmil Simenov, a general surgeon, who also spent some time in the USA and now works at Pirogov Hospital. Dr. Matev now works at Gorna Banya, a specialized Orthopedic Hospital. Dr. Simenov is establishing a small private practice at a clinic, St Pantaeimon in Sofia.

The main goal of the mission for the American team, with the help of Johanna, was to provide and share surgical techniques with our Bulgarian host. We would demonstrate the need for immediate follow-up of hand therapy and splinting. Our hope was to show how the collaboration between surgeons and therapists would result in the best outcome for the patients. Johanna strongly recommended we look at the diagnosis of flexor tendon repairs in particular. The Bulgarian medical model presently has no hand surgery specialty under plastic, orthopedics or general surgery. The flexor tendons are repaired there using a two strand repair and questionably but not always an epitendon suture. The patients are immobilized for four weeks post-op, and then seen by the physiotherapist. Although we did not personally witness this, it was noted that it was common for patients to be positioned with sutures through the nail bed and secured to the wrist to assure no motion was permitted to the healing tendon. Physiotherapists then deal with the secondary problems of immobilization, being contractures, scars and minimal tendon gliding.

We were very encouraged that we could make great progress and truly make a difference on our mission. We had a great surgeon, Dr. Ryu and two experienced hand therapists. We were able to bring and donate needed splinting supplies, as well as the latest version of the Rehabilitation of the Hand and hand protocol guidelines from my clinic, The Main Line Hand Center outside Philadelphia, Pennsylvania. Dr Ryu was happy to perform or assist with any surgery and was planning to bring surgical equipment as needed.

Our credentials were submitted, the Health Ministry was contacted and hospitals and surgeons seemed agreeable. We were all very excited to begin the mission.

Even before our trip started we ran into problems. Just months before we were set to arrive, the country experienced the “Bulgarian Healthcare Crisis of 2007”. Healthcare workers staged an unprecedented walk out and protested against low salaries, for physicians roughly the equivalent of $800 per month for nurses roughly $400 per month, and poor working conditions. On September 13, 2007 a BBC documentary on Bulgarian Abandoned Children was aired, strongly criticizing the current state of Bulgaria’s children social care homes. The program triggered a team from England to contact Sofia and offer assistance and arrange a team of three specialists to arrive in Sofia in October 2007. The Sofia Echo, the local paper, noted that the team was never allowed to see the children but could spend some time exchanging the training package of helpful techniques for interested teachers or caregivers.

These events seemed cast a negative cloud on our mission. Within weeks, Johanna informed us that the Health Ministry had not approved our request to do surgery...
or provide hand therapy in the state hospitals. Also we would not be allowed to tour the state hospitals. Private facilities rarely saw primary flexor tendon repairs and it was difficult and politically unacceptable to steer patients from the state facility to the private facilities where they would have to pay. So our missions quickly changed forms and became an exchange of information and an attempt to encourage learning to whoever would be interested.

Our Bulgarian host did their best to find facilities where we could lecture with each facility selecting lectures from topics we had available. Dr. Ryu spoke to Dr. Matev’s physicians and physiotherapist at the National University Hospital of Orthopedics on “Why our wrist is so complex and unstable” and “Articular fractures and non-unions”. The participants were engaged by Dr. Ryu’s wonderful teaching techniques that make difficult subjects easier to understand and open our minds to think out hand injury cases in a logical way.

Our “Road Trip” as we referred to it now, was off to the Physical Therapy School and National Sports Academy. To our knowledge, there are no occupational therapists in Bulgaria. We had 30 attendees, who understood very little English. Thanks to Johanna and Evgeniya Dimitrova, Ph. D, the Associate Professor, I was able to lecture on “What is a hand therapist and basic splinting” and “Flexor Tendons a review of protocols”.

We all were finally allowed to visit a private outpatient facility, St Pantaeimon Clinic, where we triaged patients with Dr. Simenov and saw the private hand clinic where Johanna sees self-pay patients for approximately $14 a visit. Unfortunately for most patients that facility is too expensive and not centrally located. Finally we were allowed some real hands-on experience with treating, splinting and collaboration of ideas for some adherent scars and significant swelling from severe crush injuries.

As a special treat, our last night we met with a true Icon, Dr. Ivan Matev, father of Dr. Boris Matev, at the National University Orthopedic Hospital. Dr. Ivan Matev was the recipient of the “Pioneer of Hand Surgery” Award for the 7th International Congress at Vancouver in 1998 and is one of 82 honored hand surgeons by the IFSSH since 1986. In his eighties, he is still seeing hand patients and involved in numerous academic ventures as well. He shared with us a copy of his book “Complication and Errors in Hand Surgery”. Dr. Matev inquired about fellow Hand Surgeons and Legacies that he knew well in the USA. In 1965, Dr Ivan Matev spent 10 months training with Dr. Eric Swanson.

Our experience was enriching for both the American team and the Bulgarian host team. We meet new colleagues and opened opportunities for both host physicians to consider visiting the USA. We left behind many donated supplies and teaching materials. We shared knowledge and planted the seeds of learning that was a big part of our overall goal for the mission.

I would like to extend my sincere gratitude to the American Association of Hand Surgery for your generosity and support of the Vargas Award. It demonstrates your commitment to the profession of hand therapy. A special thanks to Dr. Jaiyoung Ryu for his personal and professional help that made the mission a success. I also want to thank him for his assistance with AAHS in making it possible for Johanna to attend the 2007 AAHS Annual meeting in Los Angeles. What a great thrill it was to share the conference with my new Bulgarian colleague, Johanna Jacobsen-Petrov and Dr. Jaiyoung Ryu.
The excitement was filling the air at the conference hall in Heliopolis, a suburb of Cairo, Egypt. For the first time, a team of 11 faculty members of the AAHS, including its president and two past presidents, were about to start the first Cairo international hand conference. The conference, which was jointly sponsored by the AAHS and the newly formed Egyptian Society for Surgery of the Hand (ESSH), was held in Cairo, Egypt, between March 24 and 27, 2008. The conference was co-chaired by Nash Naam, MD, representing the AAHS and A. Hakim A. Massoud, MD, from the ESSH. The faculty consisted of Scott Kozin, MD, president of AAHS; Peter Amadio, MD, and Ron Palmer, MD, both of whom were past president of AAHS; Brian Adams, MD; Mark Baratz, MD; Allen Bishop, MD; Richard Brown, MD; Nash Naam, MD; Chris Novak, PT, CHT, PhD; Mike Neumeister, MD; and Jaiyoung Ryu, MD.

The conference’s format was similar to a comprehensive instructional course that covered a wide range of topics in hand surgery. The conference was attended by more than 325 participants from 14 different countries, as far away as Japan and as near as Syria and Lebanon. The conference was successful in bringing lecturers from the USA to the Middle East. The audience was very involved and engaged in the lectures. The exchange between the faculty and the audience was very lively and to a high level. The par-
Participants enjoyed the conference very much and, as a result, the ESSH now is considering asking the AAHS to co-sponsor a similar course in Cairo in March of 2010.

The faculty members had the chance to experience Cairo with its energy, charm, history, noise and contradictions. It was indeed a learning experience for the faculty and the participants. Most of the faculty members had the chance to visit Upper Egypt, where most of the Egyptian antiquities are present. Some ventured to the sunny sandy beaches of Sharm El Sheikh, which is now called the “City of Peace” because of the large number of peace conferences held there. The American faculty members and their families were well received in Egypt and their efforts were greatly appreciated.

As a by-product of this first collaborative effort, several representatives of Middle Eastern hand societies requested that the AAHS arrange for similar meetings in their own countries. Actually, the first such meeting will be held in Kuwait City, Kuwait, in January 2009. The meeting will be smaller in scale. The proposed faculty consists of: Scott Kozin, Mark Baratz, Brian Adams, Bob Russell and Nash Naam.

Our goal at this time is to help these young societies to grow and become educational centers of hand surgery, not only in their countries but in the whole region. The AAHS now has a wonderful opportunity of playing a leading role in spreading hand surgery and hand surgery education beyond the North American borders to an area that has been ignored for a long time.

These meetings will also serve as a bridge of mutual understanding and mutual respect between the people of the USA and the Middle East.
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Thumb CMC Arthritis

The moderator for this discussion is Alejandro Badia, MD, Miami Hand Center, Miami, FL. The panel is comprised of Tyson Cobb, MD, orthopedic private practice, Davenport, IA, and Randy Bindra, MD, professor, Department of Orthopaedic Surgery, Loyola University, Maywood, IL, and hand therapist Jennifer Thompson, MPT, CHT, The Philadelphia Hand Center, Philadelphia, PA.

Dr. Badia: We have this topic of CMC arthritis before us and it remains a popular topic largely due a recent resurgence of new techniques to manage this ubiquitous problem. So I’ve prepared some questions and we’ll just go around to the panelists and see where we stand. So, the first question is what conservative remedies do you feel are truly effective and when do you offer early surgery in patients immediately? In discussing conservative remedies why don’t you tell us Jenny, as our hand therapist, what you think are the most effective measures for somebody with very symptomatic basal joint arthritis?

Ms. Thompson: Fabricating an appropriate and well fitting splint is my first treatment choice. In my opinion, this is not a diagnosis that requires a formal therapy regimen. I typically have the patient come back to my clinic one time to assess the fit and use of the splint and discuss activity modification, joint protection techniques and the use of adaptive equipment. Most frequently that involves the use of enlarged pen/pencil grips and key holders.

Dr. Badia: Do you think it’s important to make a custom splint or do you think the off the shelf splints are adequate?

Ms. Thompson: I prefer to use a combination of a custom fabricated splint and a neoprene soft splint. Susan Weiss, OTR/L, CHT, Paul LaStayo, PhD, PT, CHT, Amy Mills, OTR/L, CHT, and Dale Bramlet, MD authored a wonderful article that was published in the October 2004 issue of the Journal of Hand Therapy. They found that patients prefer the neoprene soft splint.

Dr. Badia: I see, yes, the neoprene is what patients prefer. Randy what do you think – before you can talk about surgery, what do you think is really effective and what do your therapists prefer?

Dr. Bindra: The fact is that the majority of patients I see do not end up needing surgery. I couldn’t give you a figure but if I sat back here and thought I would guess only 10% to 20% would require surgery. And I think the older the patient is, the less likely that they would need surgical intervention – the younger ones often have more severe symptoms that are often difficult to control because they are more active. At my first visit, I usually give the patient a little leaflet explaining to them what arthritis is about, they see the therapist and they get the same combination of splints as Jennifer was talking about: one rigid and one soft splint. I actually have my therapist spend some time showing them adaptive devices like building up their pens and giving them advice on getting key openers etc. Once they get the jar openers and key openers and they can usually learn to adapt to live with their symptoms and the majority feel they can come to terms with their arthritis. I see them back after about 6 weeks and then offer them a shot of steroids if they are still troubled buy their symptoms.

Dr. Badia: Tyson, you’re in an area with a lot of heavy laborers, what is your take on this, and are there conservative measures that you feel are efficacious in that particular group?

Dr. Cobb: I would agree with Jenny. I think the splinting is the mainstay, obviously cortisone injections are helpful though they seem to have fallen into disfavor in a lot of circles and maybe we’re not using them as much as we used to, and that may actually be a good thing. I would agree that the patient compliance is better with the neoprene splints – I do use the thermoplastic but the patients tend not to wear them as frequently as they do the neoprene.

Dr. Badia: When do you decide right off the bat to offer somebody surgery? What do you look for?

Dr. Cobb: I agree with Randy’s position on a smaller percent needing surgery – if you’re seeing people off the street, it depends on the referral source. I think the people that come in off of the street probably fit the description that Randy’s described better, whereas if they’re

continued
referred in and have already been splinted and had steroid shots, many of these patients come in the door because they want surgery and need surgery. So in that group where they’re coming through a referral source where they’ve already been treated conservatively, most of those patients go on to surgery.

**Dr. Badia:** Okay, so speaking of surgery, the gold standard has pretty much been LRTI for several decades now, but there’s been a recent push to go back to performing simple trapeziectomy, which was described by Gervis back in 1947 I believe. So we’ve come full circle in over half of a century. Do you, Randy, think there’s any type of suspension procedure or ligament reconstruction that’s necessary? And if so, which one do you prefer?

**Dr. Bindra:** I think the whole issue is very complex because there are 2 aspects you can look at: pain relief alone versus trying to give them back strength and improved function. As far as pain relief and patient satisfaction is concerned in a patient who’s otherwise not got a very hyperextended MP joint, not got a massively subluxated CMC joint, and is a low demand, elderly patient – they seem to be quite satisfied with a simple procedure like simple excision of the trapezium. Interestingly, if you look at the literature, if you stabilize them with a K wire or not, if you give them 3 weeks to stabilize, they seem to do okay. But I think if you look critically at the objective data from all reports, whenever you take out the trapezium you will lose pinch strength – whether you do a ligament reconstruction or not. So now I am more interested in how much trapezium I retain and if I can improve pinch strength, rather than which type of ligament reconstruction is necessary. In my opinion, rather than the controversy being between trapeziectomy with or without ligament reconstruction, it is trapeziectomy versus hemi-trapeziectomy. I’m thinking that’s where we should be heading.

**Dr. Badia:** I’m going to take a guess, Tyson, that you agree with that. I think both of us have a similar approach in trying to preserve the trapezium. Are there times though where you do want to perform a trapeziectomy? And if you do, will you use a suspension procedure?

**Dr. Cobb:** Seldom. I would agree with Randy, I think that preserving most of the trapezium is the way to go, and basal joint arthritis – as

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**2009 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.

**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 3, 2008, 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
Randy pointed out – is a problem that involves many different variables. My approach is to look at the patients from the standpoint of cartilage, stability and STT involvement, and then as Randy mentioned you also have to evaluate and deal with MP instability. So the patient that comes in with cartilage that’s still intact – and, as your paper pointed out, you really can’t use the radiographic evaluation, you have to scope these patients to know for sure where they are—I’ll proceed with an arthroscopic synovectomy +/- osteotomy, depending on the amount of involvement. If it’s not intact then I will proceed with the resection arthroplasty.

**Dr. Badia:** I see. Jenny, have you seen that there is a difference in the recovery of functional pinch strength in patients who have a full trapeziectomy versus some of the newer procedures that some of us are doing?

**Ms. Thompson:** I do not have the data to compare the different procedures. Most of my experience is with the full trapeziectomy. I typically discharge these patients at post operative week 10-12, which I am not sure is long enough to determine whether recovery of functional pinch strength is different.

**Dr. Badia:** It’s interesting you say that, because the procedures that I’m favoring now, which preserve the trapezium, allow me to get them out of therapy within 4 to 6 weeks. So, I think the fact that we’re getting away from trapeziectomy may not only maintain the pinch strength better but hasten recovery as well. This prolonged recovery is one of the problems with the LRTI procedures.

**Ms. Thompson:** Yes, the chief complaint I hear from my patients is length of recovery time. This includes both joint stiffness and weakness with grip and pinch.

**Dr. Badia:** Is any type of interposition necessary then in general? Is it just a concept of putting something between the 2 surfaces? Is that important? Randy?

**Dr. Bindra:** I think if you are taking out the trapezium completely and leaving a big gap in there I am not so sure that an interposition is necessary. I think what’s important of course is to stabilize the base of the metacarpal. And usually I focus more on getting the flexor carpi radialis tendon to sling the metacarpal and just putting the remnant in the interposition. I don’t think the interposition itself is critical. However, if you do a hemi-trapeziectomy and you preserve the trapezium then I think then the interposition becomes more critical because without an interposition I think you can expect significant pain from the impingement of the retained trapezium against the thumb metacarpal.

**Dr. Badia:** And what type of interposition would you use and how do you perform your hemi-trapeziectomy?

**Dr. Bindra:** I do my hemi-trapeziectomy like I do the total trapeziectomy. If it is very unstable from pre-operative x-rays, displacement more than 40% to 50% of subluxation, then I would do a ligament reconstruction using the FCR tendon. I harvest the full thickness of the tendon and I pull the tendon through a drill hole from volar to dorsal at the base of the metacarpal. I then loop the tendon around itself in the trapezial space and anchor it to itself and the metacarpal base with multiple non-absorbable sutures. If joint subluxation is not of concern, then I would use an artificial biodegradable insert or allograft acellular dermis interposition. These avoid the added morbidity of tendon harvest.

**Dr. Badia:** And how do you stabilize it once you put that interposition material in?

**Dr. Bindra:** I usually simply advance the capsule. Some of the materials have built-in stabilizers, such as the commercially available Artelon spacer, which has wings that can be anchored to the dorsum of the joint. If I was to use acellular dermis I would just reef the dorsal capsule that I elevated to do the partial trapeziectomy. As part of the dorsal approach to the CMC, you inadvertently take off some of the abductor polis longus slips along with the capsular flap-I believe this also helps to limit subluxation of the joint postoperatively.

**Dr. Badia:** I see. And Tyson, what type of interposition, if any, do you use?

**Dr. Cobb:** I’ve used Graft Jacket, I’ve used Artelon, I’ve done some arthroscopic resections without any interposition and to be honest with you I’m not sure which one works best. They all seem to work well. I tend to feel better if I’m using some type of interposition but I don’t know for sure that it’s required.

**Dr. Badia:** That’s interesting. One of my old fellows down in Argentina, his whole group is doing arthroscopic resection and they don’t put anything in and they move them early. But I think the key with that, as Randy suggested, is that if you resect enough of the trapezium then you probably don’t need the interposition and I think that’s why their patients are doing well. I personally remove very little because I want to maintain the pinch strength, so in that case I think the interposition is necessary and I think some of these polymers that are out there do encourage fibrous ingrowth pretty well, so I think that is something that is becoming increasingly popular.

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**NOW I AM MORE INTERESTED IN HOW MUCH TRAPEZIUM I RETAIN AND IF I CAN IMPROVE PINCH STRENGTH, RATHER THAN WHICH TYPE OF LIGAMENT RECONSTRUCTION IS NECESSARY.**

RANDY BINDRA, MD
**Hand Surgery**

**INTERPOSITION BUT I BETTER IF I'M USING SURE THAT IT'S SOME TYPE OF TEND TO FEEL.**

**TYSON COBB, MD**

**AROUND THE TABLE**

continued from page 13

Tyson, what type of procedure then would you offer a 40 year old active woman who’s tried the splinting that Jenny has mentioned, a variety of different splints – maybe has had 1 to 2 injections and still has pain?

**Dr. Cobb:** What stage is she?

**Dr. Badia:** Oh I’d say she’s Eaton Stage 3 with only slight subluxation.

**Dr. Cobb:** Without instability I typically just do a resection arthroplasty with interposition through the scope with either Artelon or Graft Jacket. If they have significant instability, I add some type of stabilization procedure. I’ve been performing these through the scope as well and stabilizing the base of the first metacarpal. Many of these need to have the MP joint dealt with as well depending on how much instability and hyperextension they have at the MP joint.

**Dr. Badia:** Yes, I’m aware that you perform a procedure to pass essentially a tendon to stabilize it arthroscopically, can you tell us in a nutshell how that’s done?

**Dr. Cobb:** The one you’re referring to is a procedure where the palmaris longus is placed through a drill hole in the base of the 2nd metacarpal, this is done arthroscopically through the CMC joint. The palmaris is fixed within the base of the 2nd metacarpal with a tenodesis screw. A 2nd drill hole is then placed through the base of the 1st metacarpal exiting into the CMC joint. A suture passer is passed through the tunnel into the CMC joint and the graft is pulled out through the 1st metacarpal. The 1st metacarpal is reduced, the graft is tensioned and then the 2nd tenodesis screw is placed into the tunnel in the 1st metacarpal.

**Dr. Badia:** That’s obviously a technically demanding procedure, and for those who are adept at arthroscopy, I think a very interesting concept. How long do you immobilize them for?

**Dr. Cobb:** In the patients that have a stabilization procedure I place a K wire and leave them immobilized for approximately 6 weeks.

**Dr. Badia:** So it does appear arthroscopy’s finally made its way into our treatment algorithms. Randy, do you think there’s any role for arthroscopy in the basal joint?

**Dr. Bindra:** Yes, I do believe that it helps in the early Stage 1, for washing out the joint and doing synovectomy. In stage 2 disease, where they require an interposition, I tend to do it by an open procedure because I like to release some of the abductor pollicis longus slips and tighten the dorsal capsule. I like arthroscopic debridement but I don’t trust it completely to do the job alone, so I do like to do an open surgery and believe that the scarring and tightening the dorsal capsule does have additional benefit.

**Dr. Badia:** Have you, Jenny, seen any patients with arthroscopic management of basal joint arthritis, and if so what are your thoughts on this?

**Ms. Thompson:** No, therefore I cannot comment on arthroscopic management.

**Dr. Badia:** Well you may have the opportunity to see some of those patients come down because I know both Lee Osterman and Randy Culp do use arthroscopy in their treatment algorithm for certain stages. So it’ll be interesting to see what the hand therapists think about this. I can tell you our therapists here in Miami tell me that those patients really recover much faster and I think that’s one of the advantages of it, is just the speed of recovery, and also the minimal amount of pain. I mean patients will literally tell me they took one pain pill the night of the surgery. So that to me just in and of itself is a major advance.

I would think that, Tyson, you’ve seen something similar?

**Dr. Cobb:** We have. We looked up our results for return to full duty/activity for patients treated with LRTI vs arthroscopic resection arthroplasty with interposition. The average return to work for the LRTI group was 16 weeks, compared to 7 weeks for those treated arthroscopically. I would say that my experience has mirrored yours in Miami.

**Dr. Badia:** That’s a sizable difference, yes, Randy, do you think there’s a place for total joint replacement in this very high demand joint?

**Dr. Bindra:** You know Alex, I’ve read your paper on it and I did a few when I practiced in England. At that time we did surface replacement, not like the ball and socket design that you have reported. With surface replacement you have a little metal component on the trapeziuim which is shaped like a saddle and a similar plastic surface in the metacarpal. We had problems with fixation and found that they got loose very quickly—in about two years.

**Dr. Badia:** I’m glad you mentioned that because I think that is the key as to why total joint replacements have not caught on, particularly amongst American surgeons who have looked at the European literature and shied away from it. One, is there have been non-constrained prosthesis that have been used, such as what you describe, and the semi or completely constrained prosthesis have been put in people who are too active or perhaps too young. So I think choosing the indications is very important.
Dr. Bindra: Yes, so I have stayed away from that actually so far.

Dr. Badia: Tyson, what do you think?

Dr. Cobb: I haven’t used it. I know you are and you’re doing well with it. I’m basically standing on the sideline watching to see how things progress in that regard. Some of these soft tissue procedures do stretch out over time. Perhaps joint replacement surgery is the answer in these very unstable patients. As Randy mentioned, I think performing an open procedure and putting the right prosthesis in—the combination of those two approaches, perhaps you get enough scarring to hold the base of the 1st metacarpal in. It is significant to note that even though some of these patients after having been stabilized at both MP and the basal joint, become lax with extended follow-up, most of them are happy because they still have good pain relief.

Dr. Badia: Well that brings up a point: that many different things that we do really primarily work by giving pain relief. If you look at long term results, I think surgeons will choose a variety of procedures, because they do find exactly what you stated—that most people do well with a variety of procedures. Therefore I think that we have to look more critically at what are the ones where you get a faster recovery, as you mentioned, 7 weeks versus 16 weeks return to work, or hobbies; and perhaps which ones are less painful and less troublesome for the patient postoperatively. People are much more demanding these days, what with the educational exposure they have on the Internet and other media. So I think many of these procedures are going to be patient-driven. What do you think, Jenny? What do patients say to you when you have so much time during therapy to speak to them? What are their aspirations?

Ms. Thompson: Achieving a strong, pain-free hand that allows them to return to work, activities of daily living, and various recreational activities.

Dr. Badia: And are they frustrated about how long it takes with the classic procedure that it seems you see most?

Ms. Thompson: Yes, inevitably we hit the post operative 6 to 8 week mark and they’re still having discomfort, stiffness, and their strength levels aren’t where they want to be. This is why I feel it is important to prescribe conservative care initially. I am then able to educate the patient about the post operative rehabilitation and the timeframe that is involved. Otherwise there is a large gap between the patient expectation and the reality of the recovery time following these procedures.

Dr. Badia: Yes, that’s exactly what I’ve seen, and I think what many surgeons and patients complain about is the recovery time. Tyson also touched on the rapidity of recovery, and there is one other thing: when the trapezium is resected, we really have no bail-out. So any procedure where we do a minimal or even a semi-trapezectomy gives us an option in the future.

Randy, in the case of a failed trapezectomy, what can you offer a patient?

Dr. Bindra: This is a difficult problem. I first make sure with radiographs that the trapezium has been adequately addressed. I look for other sources of problems, such as scaphotrapezial arthritis, subluxated metacarpal base or a collapsed thumb with a hyperextended metacarpophalangeal joint. I also look for other issues, such as carpal tunnel syndrome and de Quervains tenosynovitis. I would start treatment accordingly.

Dr. Badia: Tyson, if you think the pain is really coming from the base of the thumb, and the patient’s had a complete trapezectomy, and you’ve ruled out the things that Randy has mentioned, what kind of options do you offer at that point?

Dr. Cobb: I have performed several of these types of procedures through the scope. I haven’t performed enough and I don’t have enough long term follow up to really comment on how they’re doing. I tend to hold my breath when I see these patients back in the clinic. As Randy pointed out, there are multiple variables. I use fluoroscopically-guided injections in the office to help determine the source of the pain in these patients. Sometimes the injections can be misleading, but I do find them helpful in trying to sort these difficult patients out.

Dr. Badia: It seems if a patient has persistent pain after trapezectomy there really isn’t a well defined bail-out procedure.

Dr. Cobb: I would agree with that.

Dr. Badia: The only thing I can think of is some type of sling procedure where I re-stabilize the base of the thumb, but I certainly don’t have enough experience to comment on what the success of a revision is. Are any of you aware of any literature discussing revision of LRTI type procedures?

Dr. Bindra: The only thing I’ve read about in the past, and it doesn’t seem to be popular, is fusion of the thumb metacarpal to the index with a block of bone graft from the iliac crest as an ultimate salvage.

Dr. Badia: Yes, that’s quite a salvage, when people nowadays don’t even want a primary arthrodesis, which used to be so popular. I still use arthrodesis in some of my laborers. Tyson, in your part of the country, with the patient population you see, do you use fusion?

continued
Dr. Cobb: Not much. To jump back on the last topic, I have one patient that I’m following now who presented with the base of her 1st metacarpal on the scaphoid after an LRTI. I performed an arthroscopic ligament stabilization and obtained good position of the base of the 1st metacarpal. Despite good radiographic outcome, though, she still has pain.

Dr. Badia: So even without a true joint you’re able to do what is essentially a cavity endoscopy, where you’re putting the scope in that soft tissue void?

Dr. Cobb: That’s correct.

Dr. Badia: Interesting. I think many of us would love to see that technique published.

Dr. Cobb: I’m following two of these patients right now. One has pain and one does not. When I get enough follow-up then I’ll pass that on. It hasn’t happened yet.

Dr. Badia: Osteobiologics are becoming increasingly popular, and playing an increasing role in the management of arthritic conditions. In general, what do all of you foresee on the horizon for treatment of basal joint arthritis, particularly early arthritis? Randy?

Dr. Bindra: I think one step in the right direction would be to develop an injectable degradable substance in the joint that would last longer than steroids or viscous supplementation.

I think the second step would be to restore the articular surface, similar to mosaicplasty in the knee, where we move cartilage from one area to a weight-bearing area of the joint. The ultimate goal would be to introduce a scaffold with cultured cartilage cells.

Dr. Badia: So perhaps some type of an osteoarticular transfer surgery, or OATS procedure. I’ve often thought of that same concept combined with arthroscopy, where you define the area of a focal lesion and then essentially put in a plug. I wouldn’t be surprised if some people have tried that. Tyson, if anybody’s tried it, it may be you.

Dr. Cobb: I have used the OATS procedure at the MP level, and it works reasonably well if you have a chondral lesion on one side of the joint. I have found a number of these lesions in post-traumatic patients who have normal x-rays but continue to have a swollen, painful MP joint. You don’t find the lesion until you scope the joint. If the opposing side of the joint is not involved they do well with an OATS type of procedure. There’s no reason that it wouldn’t work at the basal joint. I don’t see those patients early enough most of the time to perform that procedure. Partly because we probably give too many cortisone injections and find ourselves further down the road, so we wind up doing a resection arthroplasty instead of some type of a preferable joint salvaging procedure, such as an OATS. If we were, perhaps, more aggressive at scoping patients with early basal joint symptoms and normal radiographs, we would probably find ourselves in a position to do more of those types of procedures.

Dr. Badia: I agree completely. I think there’s a role for mosaicplasty in the early stages.

Jenny, what have you seen with patients who have had multiple steroid injections? What clinical picture do you find?

Ms. Thompson: The patient still has a symptomatic basal joint. The involved hand is generally weaker and less functional for the patient. At this point, the splint and possibly oral non-steroidal, anti-inflammatory medications are the most effective measures.

Dr. Badia: And how long do the injections give pain relief typically, in your experience?
Ms. Thompson: Six months to a year, usually longer with the first injection. Patients typically report less pain for longer periods of time if they are compliant with the splinting and activity modification I have taught them.

Dr. Badia: Could you clarify the activity modification you’re speaking of?

Ms. Thompson: I mostly educate patients to avoid both radial abduction of the thumb and accepting direct or blunt force to the thenar eminence. I also instruct patients to use a pinch that keeps the IP joint of the thumb flexed.

Dr. Badia: I see. Randy, what do you think about steroid injections in general?

Dr. Bindra: I recently was looking through the literature for a talk I was preparing, and I realized that last year Mel Rosenwasser’s group did a prospective study looking at steroid versus saline versus hyaluronic acid injection. And, guess what, they all had the same effect—which brings us back to the question—how does an intra-articular injection really work? Is it just the volume distention by diluting the inflammatory mediators in the joint, or just a placebo effect? I know that we probably will not get reimbursed for doing saline injections, but the report seems to suggest that saline injection would be the best thing! At least you’re not doing any harm. You distend the joint and wash it out and get the same relief as steroids. So it’s fascinating.

Dr. Badia: That’s a very interesting concept. I’ve never thought of it as not only the distention which might have some temporary effect, but also the dilution of the inflammatory cytokines, which is certainly one of the reasons I think arthroscopy can be so effective as well in the early stage. It’s an interesting concept.

I think that what we’ve seen in our discussion is that a lot of different things seem to work well, but there is probably a general consensus now that patients take a long time to get better from a complete trapezium resection and that we should look at other options where we’re trying to preserve the trapezium, and that perhaps even joint replacement with good indications may have a role in a certain subset of patients.

Tyson, do you have any final thoughts on where you think basal joint treatment is going?
Dr. Cobb: I think we are moving in the direction of minimally invasive procedures. As you mentioned earlier, these are patient-driven procedures. The patients get better faster and they have less post-operative pain. We’ve talked about three of the variables: the cartilage involvement, the stability and the MP joint. The other important variable is the involvement of the STT joint. If I have any question based on the clinical and radiographic evaluation, I’ll typically inject the STT under fluoroscopic control. If the STT is involved, I scope it. If the cartilage is intact, I perform a synovectomy, and if it’s not intact, I perform a resection arthroplasty with interposition.

Dr. Badia: Jenny, any thoughts? You’ve heard more of the novel procedures that surgeons are doing. Do you think that these would fit into some of the patients that you see?

Ms. Thompson: Certainly. The surgeon and therapist need to communicate about the operative procedure to develop the post-operative protocol, if it differs from that of the open LRTI.

Cia G. Passig, OTR/L, CHT

Personal: I was raised in St. Louis, Missouri. I moved to Wisconsin to attend undergraduate school, which was the first time I had been out of the state for any length of time. I did not return to Missouri for 15+ years, instead choosing to work all over the states. I have two non-human children whom I rescued from area shelters. I moved back to St. Louis in 2004 to be close to my family. In my free time I enjoy hunting for mid-century modern items at auctions and flea markets, renovating my house, and traveling.

Education: I initially attended the University of MO-Columbia primarily to go to OT school, but returned home and entered a COTA program when I did not make the class selection. After graduation I worked as a COTA while looking for a school to attend for my undergraduate degree. In 1987, I moved to Milwaukee, WI, to attend Mount Mary College. I worked as a COTA part-time while attending school and met several other COTA’s doing the same thing. I became a CHT in 1998. I began taking classes in the graduate program at University of Indiana within a few years after that.

Employer: I am presently employed by Milliken Hand Rehabilitation Center in St. Louis, Missouri. It is one of the first hand centers developed in the US, opening in 1971. I always wanted to work there if ever I returned home to St. Louis.

For many years I worked as a traveling therapist, with one of my favorite assignments at Los Angeles County Medical Center. I also had the great fortune to work with and learn from an AAHS past president for 5 years, Dr. Robert C. Russell, in Springfield, IL. It was a very educational and professionally satisfying time for me.

AAHS Involvement: During my time working with Dr. Russell, he encouraged me to apply for membership with the association, and was proactive with my attendance at my first annual meeting in Kauai. I have previously applied for the Vargas Award. This year I hope to assist with the meeting in Maui.

Best Part of My Job: After many years of being the only OT or hand therapist in a clinic, I am very happy to be working with multiple hand therapists daily and being back in a trauma setting.

Major Accomplishments: Obtaining my CHT. I am also very proud of the fact that I continued to work toward becoming an OTR, despite early detours.

Clinical Specialties: My primary background has been in trauma, I have always considered this my hand specialty. Prior to doing hands, I worked many years with neurological injuries such as CVA and SCI.

Greatest Professional Challenge: Starting a clinic from scratch. While working as a traveling therapist, I received my first trauma hospital experiences and learned great problem solving skills from that environment.

Three Words That Describe Me: Loyal, dependable and adaptable. If I were allowed to add a fourth, it would be, creative. ☞
Dr. Badia: Do you see that there’s likely a role for this in your patients?

Ms. Thompson: Definitely, but we need to evaluate the outcomes. The goal, as has been stated, is to achieve a strong, pain-free hand with a stable MP and CMC joint. The open LRTI procedure yields excellent results and is, in some cases, still the operative procedure of choice. If we are able to achieve the same results in a shorter period of time with the minimally invasive procedures then there is a role for the novel procedures. Hopefully these procedures will allow for strong, pain free use without the need for revision.

Dr. Badia: Yes, because people are more and more active, even into the older age groups.

Randy, what do you think is on the horizon? I’ll give you the last word.

Dr. Bindra: I think joint replacement needs to be further pursued. Bone fixation is the key. Once we figure out better implant retention, especially within the trapezium, I think joint replacement would become a good option. I would certainly hope that we see some developments along those lines.

Dr. Badia: Okay, well I think that pretty much summarizes the current options. I thank all of you for your input. We see that arthroscopy will have an increasing role, certainly in early stages, and perhaps even in some of the later stages, and that joint arthroplasty with the correct indications may actually catch the eye of American surgeons once again. I thank you all.

AAHS President Scott H. Kozin, MD

Scott H. Kozin, MD is the 39th President of the American Association for Hand Surgery. Dr. Kozin has been involved in the organization since and presented his first paper in 1992. Dr. Kozin’s initial interest in the association came from his mentors at the Mayo Clinic – Robert Beckenbaugh, Peter Amadio and Richard Berger, all who have been presidents of AAHS. Scott became involved with committee work beginning in 1997 and chaired the 2004 annual meeting in Puerto Rico. In 2007, he served as AAHS vice-president.

Dr. Kozin’s professional life involves clinical care and research. His practice is devoted to only upper extremity ailments in children with a focus on congenital differences, brachial plexus palsies, and spinal cord injuries. He currently is Chief of Hand Surgery at Shriners Hospital for Children – Philadelphia Unit. His academic appointment is at Temple University as an Associate Professor of Orthopaedic Surgery. Dr. Kozin’s academic work has resulted in over 100 peer reviewed publications, many chapters and a few textbooks. He is dedicated to teaching medical students, residents and fellows.

Dr. Kozin’s interest in helping children and those less fortunate extends beyond his daily work at Shriners Hospital for Children. His volunteerism has been a thrust through his career. Dr. Kozin has been an active member of Orthopaedic Overseas, and has served on their board. Scott also has been involved in Guatemala Helping Hands and joined Miguel Cruz and Rebeca Von der Heyde, 2009 program chairpersons, in an effort in Guatemala. Dr. Kozin has also accompanied Gail Groth to Uganda as part of the Vargas Traveling Fellowship. This important part of his life played an important role in shaping the theme of the 2009 annual meeting, “Volunteerism.” Dr. Kozin, Dr. Cruz, and Ms. von der Heyde have teamed up to formulate an exceptional meeting program with an underline theme of volunteerism.

Dr. Kozin is also an active member in both the AAHS and American Society for Surgery of the Hand (ASSH). He believes that both organizations can work together and have similar values and goals. Currently, the presidential line of Dr. Kozin, Dr. Nick Vedder and Dr. A. Lee Osterman are all active in both societies.

Dr. Kozin is a dedicated father to his two children, Brian (13 years old) and Samantha (11 years old). They are extremely important in his life and are expected to attend the 2009 meeting in Maui, Hawaii. He is also a devoted husband to his wife, Louise, who is a genetic counselor and often accompanies Dr. Kozin on volunteer efforts. They are even stronger as a team and are always seen together. They are both excited about the 2009 meeting in Maui, Hawaii, and hopeful you will join their entire family at this venue.
CMC Arthritis

Since we are dealing with a single diagnostic entity for this quarter’s topic on thumb CMC arthritis, the spectrum of codes that need to be discussed will be more limited than the usual Coding Corner columns. However, this subject is perhaps more difficult than the previous topics because there are many variations in operative procedures for treating thumb CMC arthritis. Furthermore, the CPT guide offers several different ways of coding for the same basic procedure.

The easiest coding considerations for treating CMC arthritis relate to the option of fusing the thumb CMC joint. This is coded for using 26841 (with or without internal fixation). If autogenous bone graft is used, then code 26842 is appropriate. If the thumb CMC joint is opened just for the purpose of a synovectomy, then code 26130 would be used. Some surgeons have reported using arthroscopy as an adjunct in treating early CMC arthritis. While no specific code exists for thumb CMC arthroscopy, it can be considered part of the wrist joint, and appropriate wrist arthroscopy codes should be used (29840—diagnostic; 29844—partial synovectomy; 29845—complete synovectomy; 29846—debridement). Codes for fusion of the thumb metacarpophalangeal joint or interphalangeal joint correspond to the codes for fusion of these joints in any finger: 26850 or 26860, respectively.

Perhaps the most common procedure performed to treat CMC arthritis is some version of an excisional arthroplasty in combination with a tendon transfer. Usually at least two codes would apply. It is important to note one way to code for use of a tendon transfer used for an interpositional graft by using 20924. Use of this code technically refers to harvesting the tendon graft through a separate incision (such as the forearm when obtaining a flexor carpi radialis graft). The codes 25310 or 26480, which code for tendon transfers in the region of the forearm or wrist, respectively, are argued by some authors as being inappropriate because the transfer used in a resection arthroplasty is not an active tendon transfer designed to provide independent motor power for the affected joint. However, an alternative viewpoint which is held by many surgeons is that the work involved in a transferring the tendon to perform a CMC resection arthroplasty is better represented by the 25310 code and consequently many surgeons prefer to use this code in conjunction with 25447.

While I do not believe that use of 25310 is misrepresenting the work of the operation, you may need to write an additional letter of explanation for any insurer that denies payment based on use of these code pairs. For a more detailed discussion of code utilization for thumb CMC resection arthroplasty, a good reference is an article in the January 2005 CPT Assistant which reviews this topic in more detail (AMA Coding Assistant, Vol. 15:1, January 2005).

As far the trapezium resection part of the operation, two codes may apply. One could use code 25210, which describes excision of the trapezium. More commonly used, however, is code 25447, which is more specific and describes “arthroplasty, interposition, intercarpal or carpometacarpal joints.” Note that if the procedure involved actually replacing part or all of the trapezium with a prosthetic device (and not a tissue graft), then use of a single code, 25445, would be appropriate.

The various procedures and corresponding codes for treating thumb CMC arthritis are summarized in the table at left.

<table>
<thead>
<tr>
<th>Thumb CMC Arthritis</th>
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<tbody>
<tr>
<td>26481 Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation</td>
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<tr>
<td>26482 Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>26850 Arthrodesis, metacarpophalangeal joint, with or without internal fixation</td>
</tr>
<tr>
<td>26852 As above, with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>26860 Arthrodesis, interphalangeal joint, with or without internal fixation</td>
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<tr>
<td>26862 As above, with autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>26130 Synovectomy, carpometacarpal joint</td>
</tr>
<tr>
<td>29840 Arthroscopy, wrist, diagnostic, with or without synovial biopsy</td>
</tr>
<tr>
<td>29844 Arthroscopy, wrist, synovectomy, partial</td>
</tr>
<tr>
<td>29845 Arthroscopy, wrist, synovectomy, complete</td>
</tr>
<tr>
<td>29846 Arthroscopy, wrist, and joint debridement</td>
</tr>
<tr>
<td>25210 Carpectomy, one bone</td>
</tr>
<tr>
<td>20924 Tendon graft, from a distance, through a separate incision</td>
</tr>
<tr>
<td>25445 Arthroplasty with prosthetic replacement; trapezium</td>
</tr>
<tr>
<td>25447 Arthroplasty, interposition, intercarpal or carpometacarpal joints</td>
</tr>
</tbody>
</table>

You Code It

A 54-year-old woman fails conservative care for her right thumb MCP arthritis pain and undergoes surgical care. The surgeon performs a fusion of the thumb MCP joint (employing a tension band construct) and uses local bone graft from the distal radius.

Solution:

26852 Arthrodesis, metacarpophalangeal joint, with or without internal fixation, with autograft
## AAHS Mentoring Program Volunteers

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 carpometacarpal; and metacarpophalangeal and PIP joints of the digits</td>
</tr>
<tr>
<td>Richard Berger, MD, PhD</td>
<td><a href="mailto:berger.richard@mayo.edu">berger.richard@mayo.edu</a></td>
<td>Wrist surgery</td>
</tr>
<tr>
<td>Kyle Bickel, MD</td>
<td><a href="mailto:kwickel@sfnhand.com">kwickel@sfnhand.com</a></td>
<td>Vascularized bone graft reconstruction for carpal pathology; complex fracture management in the hand and wrist; and arthroscopic wrist ganglion 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:kechung@med.umich.edu">kechung@med.umich.edu</a></td>
<td>Rheumatoid and congenital</td>
</tr>
<tr>
<td>E. Gene Deune, MD</td>
<td><a href="mailto:egdeune@jhmi.edu">egdeune@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@mbaibn.com">drdonlalonde@mbaibn.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:oogien@aol.com">oogien@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:loister51@bellatlantic.net">loister51@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 Pribaz, MD</td>
<td><a href="mailto:jpribaz@partners.org">jpribaz@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>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>
</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 and nerve transfers</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>
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 Crownpoint and Acoma-Canoncito-Laguna (ACL) service units located in New Mexico. 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.

CROWNPOINT is located at the Eastern edge of the Navajo Nation in New Mexico. The service unit covers 4,200 square miles and serves a user population of approximately 27,863 Native Americans. The Crownpoint Healthcare facility provides a full range of curative, rehabilitative, and preventive services to the Native American population. Crownpoint, NM is situated in the high desert where the climate is very dry and much cooler than that of the low desert. At 7000 feet, the summer days rarely top 90 degrees and the air is very cool at night.

ACL service unit is located about 1 hour west of Albuquerque, NM. The three Native American tribes primarily served are: the Acoma Pueblo, the Laguna Pueblo, and the Canoncito Band of Navajos. Healthcare is provided to approximately 14,000 tribal members from these tribes, as well as hundreds of members of these and other tribes residing in Albuquerque and surrounding communities in New Mexico. The hospital offers a wide range of outpatient and dental services as well as several specialty clinics.

The trip will be approximately September 30th - October 3rd, 2008 (Crownpoint Oct 1st and ACL Oct 2nd) and the surgeon and therapist will be funded $1,500 each for travel and lodging.

Please contact Alice Romano in the HSE Central Office at aliceromano@isms.org or 312.236.3307 if you are interested in participating.

The goal of the Indian Health Services (IHS) is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians. The IHS oversees a truly unique health delivery system that provides a wide range of medical services. The services attempt to blend traditional healing beliefs with the latest advances in medical technology.

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.

HSE President’s Report: June 2008

William Swartz, MD
HSE President

The Hand Surgery Endowment Board of Governors met this past January and reaffirmed its mission: to continue to use outreach as its vehicle to receive money from donors and to eventually return the money to the AAHS through support of its annual meeting speakers.

Nash Naam, MD and Warren Schubert, MD were appointed as members of the Board of Governors and Allen Van Beek, MD was nominated to serve as Vice President Elect. Dr. Van Beek accepted his nomination and will succeed Dr. Swartz as President in January 2010.

HSE will fund another outreach mission to the Indian Health Services again this fall to the Crownpoint and Acoma-Canoncito-Laguna (ACL) service units in New Mexico. An AAHS therapist and surgeon will provide education/in-services to a medical staff audience (MD, PA, CNP, PT, OT) on the evaluation and management of common hand injuries and conditions. For more information on the Indian Health Services and/or the upcoming opportunity in New Mexico, please contact LCDR Andra Battocchio PT, CHT, Director of Rehabilitation Services, Hand Clinic Coordinator at 928-674-7225 or andra.battocchio@ihs.gov.

Operation Smile has agreed to participate with HSE to provide outreach programs for hand surgery. The HSE will seek volunteers from the AAHS membership, and Operation Smile will handle all other logistics, including equipment, patients, scheduling, etc. HSE continues to support the Guatemala Healing Hands Foundation via an annual donation of $5,000 and we are also investigating outreach opportunities with Surgicorps.

We hope for continued support and future participation in volunteer services from the membership of the American Association for Hand Surgery.
We face difficult times for physicians and our organizations. We are busier, practice margins are tighter and the economy is fragile. Our lifeline is a love for our work and a desire to compare notes with colleagues in order to refine our skills. The AAHS helps us learn, teach and expand our network of friends and colleagues. However the viability of the AAHS is only as strong as the will of its members.

In 2007 net income for the AAHS was ($7,153) and its net assets declined to $517,062 from a 2006 value of $534,429. These changes are modest, but occurred in a year when our investment income was the highest it had been since 2003. The main reason for this was a decline in revenue from the annual meeting. Normally this would be of little concern, however the current economic climate is wreaking havoc on organizations. An aggressive approach to the problem ensures our future.

There are two solutions: raise revenue and control costs.

There is reason for optimism. The 2008 annual meeting under the leadership of Dr. Brad Meland netted approximately $100,000. In spite of a down market, our investments managed by Jeff Palmer with Smith Barney were up 2% by the end of May. AASH president, Scott Kozin and Miguel Pirela-Cruz are organizing a meeting where we will all learn and have a great time. It is typically the best attended AAHS meeting. Let’s do it again this year.

Phone a Friend. The future of the AAHS relies on an expanding membership. We have a unique organization. Tell a colleague; consider sponsoring a therapist, resident or fellow. If we are not moving forward, we are falling behind.

Respectfully submitted,
Mark Baratz, MD
AAHS Treasurer

| Table 1 |
|---|---|---|
| **Income** | 2005 | 2006 | 2007 |
| Dues | $261,390 | $224,794 | $244,884 |
| Annual Meeting | $240,615 | $339,672 | $306,902 |
| Net Annual Meeting | ($3,417) | $93,009 | $50,747 |
| Investment Income | $7,880 | $31,513 | $51,618 |

| Table 2 |
|---|---|---|
| **Expenses** | 2005 | 2006 | 2007 |
| Publications | $41,089 | $109,645 | $107,232 |
| Annual Meeting | $244,032 | $246,663 | $256,155 |
| Board/Committee | $65,153 | $86,797 | $81,588 |
| Administration | $181,620 | $220,708 | $200,815 |

| Table 3 |
|---|---|---|
| **TOTAL INCOME** | 2005 | 2006 | 2007 |
| $533,024 | $749,807 | $586,519 |
| **TOTAL EXPENSES** | $531,894 | $742,428 | $645,290 |
| **NET INCOME** | $1,130 | ($11,688) | ($7,153) |
| **TOTAL ASSETS** | $1,003,180 | $1,031,236 | $937,607 |
| **NET ASSETS** | $546,116 | $534,429 | $517,062 |