Meeting in California Set for Huge Returns

Welcome to Hollywood. As Ed Sullivan would say, “We have a really big Shoooo” for you here in Tinseltown. The 2008 annual meeting of the AAHS promises to be a colorful combination of science and entertainment meshed together with interactive dialogue designed to stimulate the minds of the old and new. Of the 118 abstracts submitted, 60 papers on basic science and clinical upper extremity surgery will be presented. This year’s meeting offers 23 different instructional courses and 5 interactive panels.

Christine Novak and Dr. Craig Johnson have worked diligently to arrange a captivating opening session on Wednesday with a focus on the management of our arthritic conditions of the hand. The program will begin early on Wednesday January 9, 2008 with Specialty Day, which will consist of a comprehensive program of didactic presentations, panels and instructional courses on the management of arthritis in the hand. The morning will begin with a review of the medical management, followed by the surgical and postoperative management of PIP and MP arthroplasty and soft tissue reconstruction. The morning will conclude with panels on wrist reconstruction, thumb arthritis and “When Bad Things Happen to Good People”. Specialty Day this year will also include 5 instructional courses and a bioskills course in the afternoon. The day will conclude with the Therapists’ Reception and the Welcome Reception, which will give everyone time to regroup and reconnect with new and old acquaintances.

Instructional courses in the afternoon will provide an opportunity for attendees to learn the current practices on various topics in hand surgery.

The opening ceremonies will be held on Thursday morning followed immediately by a panel on one of the latest advancements in hand surgery “Wide Awake Approach to Hand Surgery” moderated by Dr. Brad Meland. The keynote speaker, Ramez Naam, will discuss his latest book in a lecture entitled “More Than Human.”

On Friday, following early bird instructional courses, a controversial panel chaired by Dr. Susan Mackinnon entitled “Cubital Tunnel: Defend Your Operation” promises to provide an interesting debate from the panelists and the audience. Our president, Dr. Brad Meland, has scripted a riveting presidential address to enlighten us on his views of the future of hand surgery. The consummate enthusiast, Dr. Allen Van Beek, is this years Joseph Danyo Presidential Lecturer. Dr. Joe Slade will end the days’ scientific session with an update panel on the current issues of the Management of Scaphoid Fractures.

The conjoint session on Saturday with the ASRM and ASPN is highlighted by presentation of the top papers from each

continued on page 6
As the AAHS delegate to the AMA, I belong to the hand surgery caucus, which includes the hand surgeons who, in various capacities, serve as delegates or alternates to the AMA from various specialty and state delegations. The caucus meets at every AMA meeting and discusses topics of interest to hand surgeons. It also allows the group of hand surgeons to collectively monitor and participate in other caucuses, including the orthopaedic, plastic surgery and surgery caucuses, and the specialty and service society group, which represents roughly 40% of all AMA members.

The AMA Interim (fall) meeting is always focused on advocacy issues. The current AMA advocacy agenda supports:

- **Expanding coverage for the uninsured.** AMA is a major player here. AMA is spending $16 million to promote healthcare reform. Major features of the AMA plan: tax credits to help citizens purchase insurance; tort reform; freedom of choice for patients to choose doctors and insurance plan; freedom of choice for doctors regarding billing and practice environment. Your AMA dues support this effort.

- **Ensuring that physicians—not others—set quality standards (critical for pay for performance reform).** AMA is a major player here, and provides major support to state societies to oppose economic credentialing by insurance companies. AMA is also the main force pushing for consideration of disparities (addressing race based differences) in quality measures. The bigger AMA is, the more weight it can bring to bear.

- **Reforming the Medicare physician payment system.** The Medicare “sustainable growth rate” formula basically rewards hospitals and punishes doctors when services move from the inpatient to outpatient environment. AMA is the leader of a coalition of specialty societies that pushes Congress to reform the formula. The bigger AMA is, the more weight it can bring to bear.

- **Improving patient safety.** AMA is once again a leader; through the Joint Commission (AMA appoints 1/3 of its members) AMA influences safety standards.

- **Reforming the medical liability system.** AMA synergizes with specialty societies and supports efforts in the various states. Again, AMA dues provide significant support to the states and...
At each AMA meeting, but especially at the Interim meeting, this advocacy agenda is revised and refined. For example, a report from the Council on Medical Services recommended that the AMA support combining the Medicare Trust Funds (Parts A B and D) into a single program that offers an integrated set of services that facilitate efficient and appropriate use of care, and encourage the Centers for Medicare and Medicaid Services to explore the use of value-based, targeted benefit design to facilitate more efficient cost-sharing structure that will align incentives for patients to seek appropriate and effective care. Part A reimburses hospitals, Part B reimburses physicians, and Part D is the new drug benefit. Combining the funds would have the risk of pitting surgeons against hospitals in seeking reimbursements from a common fund. The AMA House agreed that this was problematic and referred the report for further study.

One of the more controversial resolutions was introduced by the medical students, proposing that the AMA recognize that every member of society deserves an adequate level of protection from “illness and avoidable pain and suffering related to health problems” and that providing access to quality and affordable health care is a fundamental societal obligation. There was no mention of how the “societal obligation” should be met. The resolution as written could create an immense unfunded mandate. Indeed, after some discussion, the AMA House agreed to refer the issue for further study.

I hope that this glimpse of the AMA at work has left the impression that the AMA is a serious organization. Indeed, it is the only forum available where all American physicians and surgeons come together to address issues of medical ethics, medical education, health care policy, and critical socioeconomic issues. More than that, it by far has the deepest pockets and the strongest administrative support of any American medical organization. Through the hand caucus and other groups, the AAHS has a role to play in the “House of Medicine”. This role depends on your participation as members of the AMA. I hope that you will agree that this participation is valuable. If you are already an AMA member, thank you for your support. If you are not already a member, I hope that you will consider joining. You can find further information at http://www.ama-assn.org/. Thanks!

American Association for Hand Surgery Calendar

For information contact: AAHS Central Office at 312-236-3307 or www.handsurgery.org

2008

January 9–12, 2008
38th Annual Meeting
The Westin Century Plaza Hotel & Spa
Beverly Hills, CA

March 5–9, 2008
AAOS Annual Meeting
San Francisco, CA

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

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

2009

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

February 25–March 1, 2009
AAOS Annual Meeting
Las Vegas, NV

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

October 23–28, 2009
ASPS Annual Meeting
Chicago, IL

2010

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

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

2011

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

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

Hand Rehabilitation Foundation Presents

Surgery and Rehabilitation of the Hand:
With Emphasis on the Elbow

Honored Senior Professors
Anne D. Callahan, OTR/L, CHT
Karen M. Pettengill, MS, OTR/L, CHT
Kevin E. Wilk, PT
James R. Andrews, MD
Michael R. Hausman, MD
Mr. David Stanley, MB, BSc, FRCS (Orth)
Scott P. Steinmann, MD

March 15 - 18, 2008

Chairpersons
Terri M. Skirven, OTR/L, CHT
Susan M. Blackmore, MS, OTR/L, CHT
Jane M. Fedorczyk, MS, PTA, CHT, ATC
A. Lee Osterman, MD

(25 Contact Hours) • For more information please call 215.925.4579
or visit our website at:

www.handfoundation.org
Thank You

Greetings from Scottsdale, AZ. I hope everyone is excited and registered for the annual meeting in Beverly Hills. We depend on your registration to do so many things for the membership and I would urge you, if you haven’t yet, to register online or show up at the meeting and register there. We have room for everyone. Your participation and attendance is of great importance to the Association.

This will be my last written address, as your President for 2007. I want to take this opportunity to thank, in writing, so many people who have worked behind the scenes to make this past year a successful one for me and my family and successful for the Association as a whole.

First of all, I would like to thank Christine, Craig and Mike, my program chairs, for putting together an excellent education opportunity over the four days of our meeting. Their article in this quarterly will update you as to the program and specifics and I am so grateful for the hard work and cooperation they have given me in arranging and organizing this complex meeting.

Although our meeting will be busy, there will be time to enjoy Los Angeles Thursday afternoon and evening and Saturday afternoon. If you have a favorite restaurant, or want to schedule a play or concert, I would suggest you do so before you arrive, either through the hotel service or I’m sure the Central Office at www.handsurgery.org can help you with reservations. As I’ve mentioned in my previous communications, there are several opportunities throughout the LA area that you, your spouse, family and friends can enjoy. The Central Office and hotel will do everything they can to expedite reservations and answer your questions for the activities. I’m sure as you review the program; you can see the educational opportunities are as good as they have ever been.

I want to thank my entire Board of Directors. They have given much of their time to assist me this year. All of them have done everything I have requested. No one has refused an assignment and it has been a great Board and I’ve been very proud to be a member of this Board of Directors. I am grateful for the instructional course faculty. This year we have several new instructional courses and several renewed courses that have been very successful in the past. The time and commitment of the faculty in the early mornings and afternoons for this educational endeavor is greatly appreciated.

I am grateful to Randy Bindra and his excellent faculty for again teaching on the Board Review course Friday afternoon. I hope the members continue to find this to be an educational opportunity, at minimal expense, for their board review and maintenance certification.

Thank you to the panelists and moderators for the excellent panels we have incorporating all aspects of hand surgery and therapy. Hopefully, no hand will be left behind.

Many thanks to all who have submitted abstracts. There are a record number of abstracts this year and we look forward to the paper sessions and the posters. Thank you all for your participation.

Several people worked behind the scenes, putting in many volunteer hours and are not often given accolades. I myself want to thank them now individually and I hope you will find time to shake their hand and thank them too:

First is Peter Amadio, who works very hard as Editor of Hand Surgery Quarterly and also as a delegate of the AMA. He has done so much for this organization and continues to do so. He deserves our accolades. We had our AMA audit carried out and maintained 35% of our membership belonging to the

Candidates for American Association for Hand Surgery 2008 Officers and Board

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>President</td>
<td>Scott Kozin, MD</td>
</tr>
<tr>
<td>President-Elect</td>
<td>Nicholas Vedder, MD</td>
</tr>
<tr>
<td>Vice President</td>
<td>A. Lee Osterman, MD</td>
</tr>
<tr>
<td>Treasurer (3 year term)</td>
<td>Mark Baratz, MD</td>
</tr>
<tr>
<td>Secretary</td>
<td>Keith Brandt, MD</td>
</tr>
<tr>
<td>Historian</td>
<td>Brian Adams, MD</td>
</tr>
<tr>
<td>Senior Director</td>
<td>Dean Sotereanos, MD</td>
</tr>
<tr>
<td>Junior Director</td>
<td>Eric Hofmeister, MD</td>
</tr>
<tr>
<td>Junior Affiliate Director</td>
<td>Gretchen Kaiser, ORT/L, CHT</td>
</tr>
<tr>
<td>Nominating Committee</td>
<td>Nash Naam, MD</td>
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<tr>
<td></td>
<td>George Landis, MD</td>
</tr>
</tbody>
</table>
Hand Surgery Quarterly — Winter 2008

AAHS 2008 Research Grant Winners

Principle Investigator:
Xizfeng Jia MD, PhD
Johns Hopkins University
Baltimore, MD
"Detecting and differentiating sensory signal in peripheral nerve by intraneuronal electrodes with pressure manipulation in rats"

Principle Investigator:
Christine B. Novak PT, MS, PhD(c)
Toronto General Hospital
Toronto, Ontario
"Biomedical and psychosocial factors associated with pain and disability after peripheral nerve injury"

Principle Investigator:
Damon Cooney, MD
SIU School of Medicine
Springfield, IL
"Induction of immune tolerance in rat hind limb allotransplantation by over expression of IL-10 TGF b within the transplant graft"

FROM THE PRESIDENT

continued from page 5

AMA, so we are able to maintain our house of delegate seats for Peter Amadio and Nick Vedder. I thank the members for joining the AMA.

I specifically want to thank my past presidents, who sat on the board with me, Susan Mackinnon and Ron Palmer. They have given me a lot of emotional support, a lot of great advice and I could not have done this job this past year without their incredible support and friendship.

Jai Ryu and Roberta Finley Morris recently completed their Vargas trip to Eastern Europe. I thank Jai for his support in taking Roberta on this trip and look forward to her address Thursday morning informing us about this trip.

Thank you to Bill Swartz for stepping in as President of the Hand Surgery Endowment. I am grateful to Sue Michlovitz, PT, PhD, for her help in setting up mission locations in Chinle for our United States Outreach. She spent many hours doing this and I’m sure if you are thinking of participating, she will be open to discussing it with you at the annual meeting.

I am grateful to the affiliate members of my board, Julianne Howell, Rebecca von der Heyde and Chris Novak, for their assistance and help with specialty day and for introducing a hands on splinting course for our therapists. I look forward to meeting all of the affiliates in the Presidential Suite following the meeting Wednesday for a small reception, prior to the main opening reception.

Thank you to Leon Benson, MD for his “Coding Corner” in the Hand Surgery Quarterly.

As many of you may know already, Laura Downes resigned effective October 30, 2007 as our Executive Director. It was a difficult decision for her, but professional opportunities came her way for another organization and she elected to accept. We wish her the best in her new career as Executive Director of the American Association of Diabetic Educators. Although transition of management is difficult, Alice Romano has taken over the reins as our Executive Director. The transition has gone smoothly. Alice has worked with the board and with Laura for several years and has done an excellent job in taking over since Laura’s departure. The meeting, I assure you, will run smoothly under Alice’s direction this year.

If you communicate with Laura Downes, thank her for her twelve years of service as our executive director. She is a good friend and will be missed.

Finally, as this holiday season approaches, I wish all of you health and happiness. No matter what your creed, where or how you worship, it is a special time for all of us. Diversity is important and I hope we can spend these next few weeks with family and friends sharing our love and blessings with those most important to us. Also, at this time in the world, I am so proud of the American Association for Hand Surgery for their outreach within our borders and throughout the world in volunteer services. It is the time of the year to spread peace and we certainly want peace throughout the world. In a small way we are all contributing to that through this organization.

My family and I look forward to sharing the week with you in Beverly Hills. It has been a wonderful year, lots of hard work, a few pebbles in the road, but nothing serious. I will never be able to thank you all enough for allowing me to lead this organization. It will always be the highlight of my professional career and I thank you all immensely for this opportunity. See you all in Beverly Hills, make sure you come.

Sincerely,

N. Bradley Meland, MD
AAHS President

FROM THE PRESIDENT

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tion of the top papers from each society as well as two panels, “Treatment of the Ischemic Limb” and “Tendon and Nerve Transfers: Consensus and Controversies” moderated by Dr. Michael Neumeister.

The combination of exciting speakers, panels and scientific paper presentations shall truly make this years’ AAHS a very memorable experience. Thank you to all of the participants and attendees and in the words of one of Hollywood’s finest stars, Edward G. Robinson “Look you mugs... It’s going to be swell, see... swell.”

MEETING PREVIEW

FROM THE PRESIDENT

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AAHS 2008 Research Grant Winners

Principle Investigator:
Xizfeng Jia MD, PhD
Johns Hopkins University
Baltimore, MD
"Detecting and differentiating sensory signal in peripheral nerve by intraneuronal electrodes with pressure manipulation in rats"

Principle Investigator:
Christine B. Novak PT, MS, PhD(c)
Toronto General Hospital
Toronto, Ontario
"Biomedical and psychosocial factors associated with pain and disability after peripheral nerve injury"

Principle Investigator:
Damon Cooney, MD
SIU School of Medicine
Springfield, IL
"Induction of immune tolerance in rat hind limb allotransplantation by over expression of IL-10 TGF b within the transplant graft"
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:kbickel@sfsand.com">kbickel@sfsand.com</a></td>
<td>Vascularized bone graft reconstruction for carpal pathology; complex fracture management in the hand and wrist; and arthroscopic wrist ganlion excision</td>
</tr>
<tr>
<td>Allen Bishop, MD</td>
<td><a href="mailto:bishop.allen@mayo.edu">bishop.allen@mayo.edu</a></td>
<td>Brachial plexus reconstruction; carpal vascularized bone grafts; and microvascular free tissue transfers</td>
</tr>
<tr>
<td>James Chang, MD</td>
<td><a href="mailto:changhand@aol.com">changhand@aol.com</a></td>
<td>Dupuytren's Contracture; thumb reconstruction; flexor tendon surgery; trapezial excision arthroplasty; and medial epicondylectomy</td>
</tr>
<tr>
<td>Kevin Chung, MD</td>
<td><a href="mailto:kocchung@med.umich.edu">kocchung@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@nb.aibn.com">drdonlalonde@nb.aibn.com</a></td>
<td>Wide awake approach to hand surgery</td>
</tr>
<tr>
<td>W. P. Andrew Lee, MD</td>
<td><a href="mailto:leewp@upmc.edu">leewp@upmc.edu</a></td>
<td>Post traumatic hand reconstruction; mini incision carpal tunnel release</td>
</tr>
<tr>
<td>Susan Mackinnon, MD</td>
<td><a href="mailto:mackinnons@wustl.edu">mackinnons@wustl.edu</a></td>
<td>Ulnar nerve surgery</td>
</tr>
<tr>
<td>Nash Naam, MD</td>
<td><a href="mailto:dnaam@handdocs.com">dnaam@handdocs.com</a></td>
<td>SLAC wrist reconstruction; vascularized bone graft in treating scaphoid nonunions; ulnar shortening &amp; radial shortening; PIP &amp; MP joint arthroplasty; LRTI; arthroscopy of the CMC joint of the thumb</td>
</tr>
<tr>
<td>Daniel J. Nagle, MD</td>
<td><a href="mailto: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:rneumeister@siumed.edu">rneumeister@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:joster51@bellatlantic.net">joster51@bellatlantic.net</a></td>
<td>Advanced wrist arthroscopy and small joint arthroscopy. Can also mentor a topic such as DRUJ problems, or wrist fracture.</td>
</tr>
<tr>
<td>Julian J. Pribaz, MD</td>
<td><a href="mailto: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:ezoook@siumed.edu">ezoook@siumed.edu</a></td>
<td>Fingertip reconstruction</td>
</tr>
</tbody>
</table>
AAHS 38th Annual Meeting
Program at a Glance
January 9–12, 2008
Hyatt Regency Century Plaza Hotel and Spa, Beverly Hills, CA

AAHS
Tuesday, January 8, 2008
2:00–5:00pm AAHS Board of Directors Meeting

AAHS
Wednesday, January 9, 2008
6:30–7:30am Continental Breakfast
7:00–7:15am President/Program Chair Welcome
N. Bradley Meland, MD, President
Michael Neumeister, MD, Program Chair
Craig Johnson, MD, Program Chair
Christine Novak, PT, MS, Program Chair
7:15–9:05am Medical/Surgical Management
Craig Johnson, MD, Moderator

7:15–7:40am Pathogenesis & Medical Management
Steven Ytterberg, MD

7:40–8:20am DIP/PIP
7:40am PIP Arthroplasty
Robert Beckenbaugh, MD
8:05am Post Op Management Following PIP Arthroplasty
Ann Lund, OTR, CHT

8:20–8:55am MP
8:20am MP Arthroplasty
Steve Moran, MD

8:40am Post Op Management Following MP Arthroplasty
Paul Brach, MS, PT, CHT

8:55am Discussion & Questions
9:05am BREAK

9:25–10:45am Soft Tissue Reconstruction
Christine Novak, PT, Moderator

9:25am Tendon Reconstruction
James Chang, MD

9:45am Post Op Management Following Tendon Reconstruction
Rebecca von der Heyde, MS, OTR/L, CHT

10:00am Surgical Management of Raynaud’s Phenomenon
Michael Neumeister, MD

10:20am Post Op Management
Julianne Howell, PT, MS, CHT

10:35am Discussion and Questions

10:45am PANEL: Wrist Reconstruction
Mark Baratz, MD, Moderater
Brian Adams, MD
A. Bobby Chhabra, MD
Michael Hayton, MD
Steve Moran, MD

11:00am–12:30pm Past President’s Lunch

11:40am PANEL: Thumb Arthritis: Challenges & Management
Peter Murray, MD, Moderator
James Chang, MD
Matthew Tomatino, MD
Thomas Trumble, MD

12:35pm LUNCH

12:55pm PANEL: When Bad Things Happen to Good People
A. Lee Osterman, MD, Moderator
Peter Amadio, MD
Daniel Nagle, MD
A. Lee Osterman, MD
William Swartz, MD

2:30–3:30pm Hand Surgery Endowment Board of Governors Meeting

2:00–3:00pm Instructional Courses
101 Distal Radius Fracture
Brian Adams, MD, Moderator
William Geissler, MD
Ronald Palmer, MD
Ann Kammien, PT, CHT

102 DRUJ
Mark Baratz, MD, Moderator
Daniel Nagle, MD
Maureen Hardy, PT, MS, CHT

103 Flexor Tendon Repair
Michael Neumeister, MD, Moderator
Peter Amadio, MD
Donald Lalonde, MD
Avisul Wolff, BSc, OTR/L, CHT

104 Extensor Tendon Injuries
Wyndell Merritt, PT, MS, CHT
Julianne Howell, PT, MS, CHT

2:00–4:00pm Instructional Course
105 An Algorithmic Approach to Treatment of CMC-I Arthritis
Sponsored by: Small Bone Innovations
Alejandro Badia, MD
Randip Singh Bindra, MD
Tyson Cobb, MD
A. Lee Osterman, MD

3:00–4:30pm Instructional Courses
106 Splinting Challenges—Practical Pearls
Julianne Howell, PT, MS, CHT, Moderator
James Gyovai, PT, CHT
Rebecca von der Heyde, MS, OTR/L, CHT

5:00–6:00pm Therapists’ Reception
6:00–8:00pm Welcome Reception
**AAHS**

**Thursday, January 10, 2008**

6:30–8:00am  Continental Breakfast with Exhibitors

7:00–8:00am  Instructional Courses

107 Fractures of the Hand
   Donald Lalonde, MD
   Stephen Trigg, MD
   Mary Burns, OT

108 PIP Joint Stiffness
   Robert Beckenbaugh, MD, Moderator
   Joseph Slade, MD
   Ann Lund, OTR, CHT

109 Vascularized Bone Grafts
   Steven Moran, MD
   Michael Saurbier, MD

110 Scapho-Lunate Injuries
   Randipsingh Bindra, MD, Moderator
   Michael Hayton, MD
   Jai Rya, MD

111 Cost Effective and Tax Efficient Managed Money for Physicians
   Patrick Donnelly, Smith Barney Consulting Group
   Jeff Palmer, Smith Barney Consulting Group

8:10–8:45am  Welcome
   N. Bradly Meland, MD, President
   Michael Neumeister, MD, Program Chair
   Craig Johnson, MD, Program Chair
   Christine Novak, PT, MS, Program Chair
   Steven Glickel, MD, ASSH President
   Richard D’Amico, MD, ASPS President
   Roberta Finley Morris, OTR/L, 2007 Vargas Recipient

8:45–10:15am  PANEL: Wide Awake Hand Surgery
   N. Bradly Meland, MD, Moderator
   Donald Lalonde, MD
   Wyndell Merritt, MD
   Matthew Concannon, MD

10:15–10:45am  Break with Exhibitors

10:30–11:30am  Hand Journal–Editorial Board Meeting

10:45am–12:35pm  Concurrent Scientific Paper Session A

10:45am–12:35pm  Concurrent Scientific Paper Session B

12:35–1:00pm  Lunch With Exhibitors

1:10–1:40pm  Keynote Speaker: Ramez Naam
   “More Than Human: From Therapy to Enhancement”

1:45–2:15pm  PANEL: Scaphoid Fractures
   Joseph Slade, MD, Moderator

2:30–3:30pm  Instructional Courses

112 Complex Hand Trauma
   Nicholas Volder, MD, Moderator
   Steven Moran, MD
   W. P. Andrew Lee, MD

113 Tumors of the Upper Extremity
   Gene Deune, MD

114 Nerve and Tendon Transfer
   Susan Mackinnon, MD, Moderator
   Neil Ford Jones, MD
   Christine Novak, PT, MS

115 The Assessment and Treatment of Peripheral Nerve Injuries in Children
   Scott Kozin, MD, Moderator
   Howard Clarke, MD
   Lynn Bassini, OTR, CHT

116 Anatomy and Care of the Perionychium
   Elvin Zook, MD, Moderator

**AAHS**

**Friday, January 11, 2008**

7:00–7:30am  Annual Business Meeting

7:00–8:30am  Continental Breakfast

7:30–8:30am  Instructional Courses

117 Thumb Reconstruction
   James Chang, MD, Moderator
   Rudy Buntic, MD
   Neil Ford Jones, MD

118 Outcomes of Nerve Decompression
   Steven McCabe, MD, Moderator
   Kevin Chung, MD

119 NCS Nerve Electrophysiology
   Allen Van Beck, MD, Moderator

120 Basilar Joint Arthritis
   Nash Naam, MD, Moderator
   Miguel Saldana, MD
   Jennifer Thompson, PT

121 Periarticular Elbow Fracture Dislocations: Will My Elbow Bend Again?
   Robert Gaitz, MD, Moderator
   Paul Brach, PT, MS, CHT
   Dean Soteranos, MD

122 Financial Planning for the Newly Established Surgeon
   Patrick Donnelly, Smith Barney Consulting Group
   Jeff Palmer, Smith Barney Consulting Group

8:35–9:35am  PANEL: Cubital Tunnel: Defend Your Operation
   Susan Mackinnon, MD, Moderator
   Daniel Nagle, MD
   A. Lee Osterman, MD
   Dean Soteranos, MD
   Tyson Cobb, MD

9:35–10:00am  Presidential Address
   N. Bradley Meland, MD

10:00–10:30am  Joseph Danyo
   Presidential Invited Lecturer: Allen Van Beek, MD
   “Handing Back Options”

10:30–11:00am  Break with Exhibitors

11:00am–12:45pm  Concurrent Scientific Paper Session C

11:00am–12:45pm  Concurrent Scientific Paper Session D

12:00–2:30pm  Board of Directors Luncheon/Meeting

12:45–6:10pm  Comprehensive Hand Surgery Review Course
   Randipsingh Bindra, MD, Chairman

12:45–1:00pm  Vascular Disorders of the Hand/Reimplantation
   William C. Pederson, MD

1:00–1:20pm  Compressive Neuropathies & CRPS
   Daniel Nagle, MD

1:20–1:40pm  Thumb Basal Joint Arthritis and Wrist Arthritis
   Alejandro Badia, MD

1:40–2:00pm  Inflammatory Arthritis of the Hand and Wrist
   Matt Tomaiolo, MD

continued on page 10
AAHS 2008 Program-at-a-Glance
Friday, January 11, 2008

2:00–2:15pm Distal Radius Fractures
   Peter J. L. Jebson, MD

2:15–2:30pm Distal Radial/ulnar Joint
   Brian Adams, MD

2:30–2:45pm Scaphoid Fractures and Non-Unions
   Mike Hayton, FRCS

2:45–3:00pm Brachial Plexus Injuries
   Randy Bindra, MD

3:00–3:15pm Carpal Instability
   Peter Amadio, MD

3:15–3:30pm Fractures of the Metacarpals and Phalanges
   David Dennison, MD

3:35–3:50pm Flexor Tendon Injuries
   Kevin J. Renfree, MD

3:55–4:10pm Infections of the Hand
   Kevin D. Plancher, MD, MS, FACS, FAAOS

4:10–4:30pm Congenital Hand Differences
   Scott H. Kozin, MD

4:30–4:50pm Tumors of the Hand and Wrist
   Michael Bednar, MD

4:50–5:10pm Soft Tissue Coverage in the Hands
   Loree Kallianen, MD

5:10–5:30pm Tendon Transfers for the Hand
   Randipsingh Bindra, MD

5:30–5:50pm Tendonopathies and Dupuytrens Contracture
   Peter Murray, MD

5:50–6:10pm Questions/Adjourn

7:00 pm AAHS Salsa Sensation
Awards Dinner & Dance

7:00–7:15am Presidents’ Welcome
   N. Bradley Meland, MD, AAHS President
   Gregory R. D. Evans, MD, ASPN President
   Lawrence B. Cale, MD, ASRM President

7:15–8:15am Panel: Treatment of the Ischemic
   Limb
   William C. Pederson, MD, Moderator
   Chris Attinger, MD
   Craig Johnson, MD
   Michael Neumeister, MD

8:15–8:45am Breakfast with Exhibitors

8:45–9:45am Panel: Tendon and Nerve Transfers for
   Common Upper Extremity Palsies:
   Consensus and Controversies

9:45–10:45am AAHS/ASPN/ASRM Presidents Invited
   Lecture: Aaron Vinik, MD
   “Neurovascular Dysfunction in Diabetes”

10:45–11:30am AAHS/ASPN/ASRM Outstanding Paper
   Presentations

AAHS/ASPN/ASRM Combined Day Program
Saturday, January 12, 2008

6:30–7:00am Coffee

7:00–6:00pm ASRM Patient Safety
Computerized Presentations

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Tendonopathies and Dupuytrens Contracture  
Peter M. Murray, MD

Compression Neuropathies & CRPS  
Daniel J. Nagle, MD

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

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

Distal Radius Fractures  
Peter J. L. Jebson, MD

Distal Radio-Ulnar Joint  
Brian D. Adams, MD

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

Carpal Instability  
Richard A. Berger, MD, PhD

Metacarpal and Phalangeal Fractures  
Stephen D. Trigg, MD

Extensor Tendon Injuries  
Kevin J. Ranier, MD

Flexor Tendon Injuries  
Kevin J. Ranier, MD

Infections of the Hand  
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Scott H. Kozin, MD

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Edward A. Athanasian, MD

Peripheral Nerve Injury and Reconstruction  
Michael B. Wood, MD

Tendon Transfers  
Michael B. Wood, MD

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

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

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Joint Replacement in the Hand and Wrist

The topic for this edition of *Hand Surgery Quarterly* is joint replacement in the hand and wrist. There are a total of nine codes that relate to arthroplasty in the wrist and four codes that specify an arthroplasty procedure in the hand.

Of the nine arthroplasty codes relevant to the wrist area, two of them deal with “interpositional” arthroplasty procedures which are not really the focus of this edition of the *Hand Surgery Quarterly*. Nonetheless, I have included these two codes in the table below for the sake of completeness. Code 25332 describes interpositional arthroplasty when performed at the level of the wrist joint, and code 25447 is the familiar code used to describe a CMC resection arthroplasty. When using the primary descriptor for interpositional arthroplasty, it is often appropriate to use additional codes to describe the work performed in obtaining fascia for the arthroplasty or using a tendon transfer.

There are six codes that describe a prosthetic arthroplasty at the level of the wrist. Codes 25441, 25442, 25443, 25444, 25445, and 25446 all correspond to joint replacement at the level of wrist depending upon which surface is replaced: distal radius, distal ulna, scaphoid, lunate, trapezium, or total wrist (distal radius and part or all of the carpus), respectively. Code 25449 is used to describe revision of a wrist level arthroplasty and includes the work performed in removing implants.

There are four codes that relate to arthroplasty at the finger level. Codes 26530 and 26535 describe either metacarpophalangeal or interphalangeal joint arthroplasty, respectively, without use of a prosthetic implant (i.e. soft tissue interposition). Codes 26531 and 26536 are used to describe implantation of a prosthesis to replace the joint at either the metacarpophalangeal or interphalangeal joint level.

**You Code It**

A 72 year man with osteoarthritis undergoes a total wrist arthroplasty using an unconstrained device that resurfaces both the distal radius as well as the proximal carpal row.

**Solution:** Code 25446

**CORRECTION for Burns and Mutilating Hand Injuries**

In the Autumn 2007 edition of *Hand Surgery Quarterly*, the table listing codes for skin graft related procedures included two codes that are no longer used (15000 and 15001) and also was incomplete regarding codes for the wide variety of graft materials currently available. This material has been corrected in the tables on the next pages, and the “You Code It” example provided has also been corrected to reflect current descriptors. The source material used for the previous column was not up to date, and I apologize for any confusion this may have caused.

**You Code It**

A 26 year old worker sustains a burn injury to his dorsal forearm that is first surgically debrided and then covered with a split thickness skin graft. The total area involved is 55 square centimeters.

**Solution:** Codes 15100 and 15002-51
<table>
<thead>
<tr>
<th>Surgical Preparation</th>
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<tbody>
<tr>
<td>15002</td>
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<td>15003</td>
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<td>15004</td>
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<td>15005</td>
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<table>
<thead>
<tr>
<th>Adjacent Tissue Transfer or Rearrangement</th>
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</thead>
<tbody>
<tr>
<td>14000</td>
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<tr>
<td>14001</td>
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<tr>
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<td>14350</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Grafts: Autograft/Tissue Cultured Autograft</th>
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</thead>
<tbody>
<tr>
<td>15100</td>
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<tr>
<td>15105</td>
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<td>15430</td>
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<td>15431</td>
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**Grafts: Xenograft**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15570</td>
<td>Formation of direct or tubed pedicle, with or without transfer; trunk</td>
</tr>
<tr>
<td>15572</td>
<td>Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs</td>
</tr>
</tbody>
</table>

**Grafts: Acellular Dermal Replacement continued**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>15577</td>
<td>formation of direct or tubed pedicle; first 25 sq cm or less or 1% of body area of infants and children</td>
</tr>
<tr>
<td>15578</td>
<td>as above in 15577, each additional 25 sq cm or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

**Flaps (Skin and/or Deep Tissues)**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>15571</td>
<td>Formation of direct or tubed pedicle, with or without transfer; trunk</td>
</tr>
<tr>
<td>15572</td>
<td>Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs</td>
</tr>
</tbody>
</table>
Start or Finish?

Rebecca L. von der Heyde, MS, OTR/L, CHT
Junior Affiliate Director

The early bird gets the worm.
—American proverb

When covering a clinic last week, I saw three patients with proximal phalanx fractures over the course of one morning. All three patients were more than twelve weeks post-surgery and all three patients had terrible proximal interphalangeal joint motion. To make matters worse, the therapists had tried every possible combination of active motion, passive motion, dynamic splinting, resistive exercises for tendon gliding, and functional use to no avail. Inevitably the question came to mind: why such poor outcomes?

In reviewing each chart, the problem became quickly apparent: no early active motion. Up to three weeks of conservative treatment led to as many as six months in therapy. The next step? More surgery and more therapy. There must be a better way.

My clinical experience as a hand therapist has led me to a distinct conclusion: the way we start determines how it will end. In my professional opinion, initiation is more critical than progression. Despite the fact that we can often salvage functional motion after long periods of immobilization and conservative management, it doesn’t have to be so difficult.

Our surgical and therapeutic literature supports early motion for multiple diagnoses. Early synergistic wrist motion has been shown to increase differential tendon excursion. The careful progression of early active motion for patients with unstable extra-articular hand fractures has been established within the first three weeks as a means to facilitate both bony and soft tissue recovery. More recently, early active motion after volar plate fixation of distal radius fractures has led to more efficient functional outcomes.

Of course, the use of early motion requires a commitment from both surgeon and therapist. A collaborative approach that includes transparent communication, familiarity with current scientific evidence, and flexibility regarding the consideration of alternative methods is essential. Increasing our focus on an early start may certainly lead to a more efficient and positive finish.

REFERENCES:
Debby Schwartz, OTR/L, CHT

**Personal:** I was born in Sioux City, Iowa, but my family moved to Jerusalem, Israel when I was a young teenager. I finished high school in Jerusalem, served in the Israeli army, and met my husband on a kibbutz! We returned to the US to complete our educations and begin our family. We have three children, and it is hard for me to realize that our eldest son has already graduated from college, our daughter will graduate in the spring and our youngest will soon be driving himself to high school! My husband and I love traveling and hiking together. When we are at home, you can find me in my basement pottery studio, throwing bowls and mugs on my wheel.

**Education:** I graduated from the Occupational Therapy program at Downstate Medical Center in Brooklyn, NY. I was able to complete my affiliation in Physical Rehabilitation at Hadassah Hospital in Jerusalem, Israel, which helped launch my keen interest to travel and learn about our profession as it is practiced all over the world.

**Employer:** After twenty-two years as a clinician, I now work for Orfit Industries America as Product and Educational Specialist for Physical Rehabilitation. Orfit Industries is a plastics manufacturer of high quality thermoplastics for splint fabrication. I am busy conducting splinting workshops and in services to promote Orfit materials. This position allows me to travel all over the United States and promote excellence in splinting education.

**AAHS Involvement:** I have been a member for three years and I am excited to be attending my first Specialty Day at the January 2008 meeting.

**Best Part of My Job:** I love to travel and meet other therapists, and share ideas on treatments and splint fabrication. I hope to learn something new everywhere I go and pass that tidbit on to the next group of therapists that I meet. My new position allows me great creativity and flexibility.

**Major Accomplishments:** I was thrilled to be selected as the first recipient of the Evelyn Mackin Traveling Hand Therapist Award in 2005. I traveled to Norway and London, and presented talks on Tendon Transfer Management and American hand therapy to many clinics. I was also excited to participate in the International Federation of Societies for Hand Therapy (IFSHT) meetings in Scotland in 2004 and in Australia in 2007. At both conferences, I offered original papers on contrast baths and the use of continuous passive motion in hand therapy. Presenting several talks at the 10th anniversary conference of the Venezuelan Hand Therapy Society in Caracas in 2006 was also a wonderful and rewarding experience.

**Clinical Specialties:** I especially enjoy working with tendon transfer patients. While working at Shriners Hospital for Children in Philadelphia, I had the unique experience of treating a variety of children who underwent this procedure. My caseload included children with spinal cord injuries, Cerebral Palsy, Brachial Plexus Palsy and Arthrogryposis.

**Greatest Challenge:** Leaving the hand therapy clinic and heading into the corporate educational world at this point in my career should prove to be a positive, exciting and challenging opportunity!

**Three Words That Describe Me:** Energetic, engaging, creative.

Debby Schwartz, OTR/L, CHT
AROUND THE HAND TABLE

New Joint Replacements of the Hand and Wrist

The moderator for this Around the Hand Table discussion is Brian Adams, MD, University of Iowa, Department of Orthopedic Surgery, Iowa City, IA. Joining him are: hand surgeons Robert Beckenbaugh, MD, Professor of Orthopedics, Consultant in hand surgery, Mayo Clinic, Rochester, MN, Peter Murray, MD, Professor of Orthopedic Surgery, Mayo Clinic, Jacksonville, FL, and Kevin J. Renfree, MD, Assistant Professor, Department of Orthopaedic Surgery, Mayo Clinic Arizona, Scottsdale, AZ; and hand therapist Paul Brach, PT, MS, CHT, The Hand Center of Pittsburgh, Pittsburgh, PA.*

DR. ADAMS: We’re not going to be discussing traditional silicon implants, but rather the newer implant arthroplasties that have been introduced over the last several years. Perhaps our most important concern is defining the indications for these new implants, and whether the overall indications for arthroplasty are increasing because of these new designs. With a lack of substantial clinical studies, we might want to consider our opinions regarding their relative benefits, if they exist, over traditional silicone implants. In this theme, we may want to consider the ideal and the worst patient. Although we can’t discuss surgical techniques in detail, my opinion is that a successful outcome with a new implant often depends on attention to operative detail, particularly since the techniques tend to be more challenging than with traditional implants. It’s also important to recognize that many newer implants require more intensive rehabilitation and follow up. And of course, we need to consider complications, in particular salvage of failed implants, especially since revision surgery may be more difficult with these more complex replacements.

DR. MURRAY: I’m still primarily bound by age, pain and activity level. I typically don’t prefer to put these in people who are active or think they’re going to be active beyond the usual activities of daily living. Clearly if there’s been an infection, open fracture occurs. I’ll also consider that a relative contraindication.

DR. BECKENBAUGH: With pyrocarbon implants neither open fracture nor a history of infection is considered a contraindication to surgery. If one year has passed with no sign of infection, particularly following trauma, I will not hesitate to proceed with reconstruction with total joint replacement. I have not encountered any recurrent infections in this scenario. Recurrent infection may be a greater concern if cement is used.

DR. RENFREE: I would say yes, but I still think the main indication in my practice is severe pain. I’ll have patients that occasionally come in that don’t have a lot of pain, but rather a main complaint of stiffness and/or deformity. They inquire about a joint replacement to improve motion and activity so they can grip things like a golf club better, or to improve the appearance of their hands. Even though these newer implants are more durable compared to silicone, I don’t think that patients get a predictable improvement in range of motion over what they have preoperatively. The biggest advantage of the surface replacement is that because they more closely mimic the normal joint anatomy, are not constrained, and are made of durable materials, they can be used in younger, more active patients without the fear of implant fracture, as is seen with silicone implants, and the subsequent osteolysis that you see in upwards of 40% to 50% of patients.

* Industry Relationship Disclosures: Brian Adams, MD, Consulting (Ascension Orthopedics, Integra Life Sciences); and Robert Beckenbaugh, MD, Consulting (Ascension Orthopedics, SBI)

ALTHOUGH TRADITIONALLY WRIST REPLACEMENT WAS PERFORMED PRIMARILY FOR RHEUMATOID ARTHRITIS, THESE PATIENTS ARE OFTEN POOR CANDIDATES.

BRIAN ADAMS, M.D.
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.

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 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
Renfree, have you adopted this approach or do you prefer other approaches?

DR. RENFREE: I use the volar approach for the long finger, ring finger, and small finger. I like it because I think it improves the exposure and preserves the extensor mechanism. I do release the collateral ligament, but I typically will buddy strap the digit for 12 weeks if I'm doing a single digit. I'll have them buddy strap to the adjacent digit, to allow a “neo-collateral” ligament to form. I haven’t found the volar approach to be a problem in the small finger, but I have found it to be a problem in the index finger with release of the radial collateral ligament with late deformity, recurrent valgus deformity from incompetence or stretching of the radial collateral ligament. I think the stresses from pinch, etc. can be just too great for that neo-collateral ligament to stand up to over time. I think the lateral approach on the ulnar side of the index finger is very helpful because you’re preserving the radial collateral ligament and also the volar structures. Of course the main advantage of both the lateral and volar approaches is preservation of the extensor mechanism so active motion can begin right away without worrying about it scarring down or stretching out.

DR. BECKENBAUGH: We have currently changed to a lateral approach in most patients who do not have excessive osteophyte formation dorsal or medially and laterally that we wish to address. The approach is always made on the ulnar side with a Z-type plasty division through the middle of the collateral ligament leaving the dorsal half based on the proximal phalanx and the palmar half attached to the middle phalanx. This technique has been introduced by Mazzone in Italy and is especially effective in those patients with a lot of ulnar deviation deformity. If there are excessive osteophytes that need to be débrided we now reattach the central tendon to the middle phalanx through drill holes prepared before the implant is inserted, so there is a large bite of bone. Post-operatively in these cases the extend-and-hold techniques of extensor tendon repair are used in therapy along with occasional extension block splinting. Motion however may be begun in earnest within 2 weeks with these techniques. 70 to 85 degrees flexion is often achieved with these methods.

DR. ADAMS: Let’s move on to the MCP joint. I still use traditional silicone replacements for the rheumatoid patient, but I prefer the pyrocarbon implant for osteoarthritis and the occasional posttraumatic patient. In fact, there are reports that pyrocarbon implants are successful as a hemi-arthroplasty in posttraumatic conditions. Dr. Murray, are you finding an increase in the indications for non-silicone implants in the MCP joint?

DR. MURRAY: I’d say yes. And I would reserve that indication, at least I tend to reserve that indication in my practice to perhaps a little bit younger patient with either one or two MCP joints that are affected by osteoarthritis that have reasonably good bone stock. I’ve found the balancing of the surface replacement MCP’s to be a little bit more technically challenging and a little bit more time consuming.

DR. ADAMS: Dr. Renfree, have you found any difference between the metal-on-poly and the pyrocarbon implants at the MCP joint?

DR. RENFREE: I have used both of them, but more often the pyrocarbon. I am a little concerned about the need for cement with the surface replacement (metal and polyethylene) implant simply because removal, in the event of a post-operative infection, could result in marked bone destruction which might limit future reconstructive options. It’s a little easier for me to machine and broach the bones in the metacarpal and proximal phalanx for a nice press fit than it is in the middle phalanx for the PIP joint, which is why I am less inclined to use pyrocarbon for the PIP joint. With the pyrocarbon implants, it is helpful to trial early, after the first or second broach, to make sure that the rotational and angular alignment is satisfactory. If you wait until the final implant size to trial and aren’t happy with the alignment, it is hard to adjust and still get a good press fit. With the semiconstrained (metal and polyethylene) implants, you can usually cement in a smaller implant (usually just one size) to correct the unsatisfactory alignment. The semiconstrained (metal and polyethylene) implants have been helpful for revisions of failed pyrocarbons or silicone where there’s been a lot of osteolysis and you can’t get a good press fit with a pyrocarbon, because you can use cement to fill up the osteolytic cavity.

DR. BECKENBAUGH: In osteoarthritis and traumatic arthritis the pyrocarbon and cemented polyethylene and metal prostheses have been very successful joint replacements. In our experience with rheumatoid arthritis, like Dr. Renfree, we are cautious to use pyrocarbon only with minimal deformity, good bone stock and relatively younger patients. If there are strong volar subluxation forces in RA the poly portion of the SR implant will deform or wear resulting in subluxation and recurrent extensor lag. If the patient is on some of the new RA medications or even NSAIDs, we have occasionally seen total loss of fixation of pyrocarbon implants at both the MCP and PIP. At this time we are not sure of the exact mechanism but if the patients have...
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soft bone, are hypermobile or “loose” types of arthritic patients, intrinsically more stable silicone implants are appropriate as well as in those patient where surgery must is being performed for severe deformities.

DR. ADAMS: Mr. Brach, do you have specific keys for successful rehabilitation following MCP arthroplasty? And does it differ among the pyrocarbon, metal on poly and silicone implants?

MR. BRACH: Traditionally, the initial rehabilitation post-operatively for an MCP arthroplasty has been fabrication of a dynamic splint to passively assist the MCP joints back into full extension after being actively flexed. The splint is worn during the day. Another splint is fabricated for night time use; a simple static forearm based pan splint that maintains proper neutral alignment of the MCP joints as well as keeping the MCP’s and the IP joints in full extension. I think that the key to achieving a proper outcome is to make absolutely sure that the patients understand to flex from the MCP joints and not the IP joints, i.e., achieve a full composite fist in the splint vs. a hook fist. Another key when you’re fabricating these splints is to make sure that the dynamic splints have a slight radial pull to them to maintain alignment as well as to prevent any ulnar drift that may occur from loosening of the rubber bands on the dynamic splints. In light of these facts, I believe the goals for the silicone implants would be similar to pyrocarbon, where you’re basically trying to alleviate the ulnar drift deformity, improve stability and provide additional mobility for these patients. Again, my experience with pyrocarbon isn’t that extensive as opposed to the more traditional ones.

DR. BECKENBAUGH: I agree with Mr. Brach in general, but the difficulty is achieving flexion with silicone implants and maintaining extension with pyrocarbon implants at the MCP. Thus generally in RA we use active assisted motion with silicone, and with pyrocarbon in RA we use a motion limiting exercise program, to try and achieve full extension and only 40 degrees of flexion or so. If the silicone protocols are used with pyrocarbon in RA, excess flexion will be obtained with eventual recurrent extensor lag, which is not desirable.

DR. ADAMS: Earlier Dr. Renfree mentioned salvage following a failed MCP implant, and we’ve also discussed PIP joints. Dr. Murray, what is your preferred method to treat the failed PIP and MCP joints?

DR. MURRAY: First, I’d make sure it wasn’t secondary to infection. If it’s a failure of technique then I am inclined to revise it at least once. And as I’ve said earlier, the most common technical failure that I’ve seen is the implant being too small with the proximal phalanx subsiding, and then essentially no joint motion of the joint due to impingement of the middle phalanx on the volar aspect of either the implant or the remaining bone in the proximal phalanx. If it’s a problem with the extensor mechanism then that’s a very difficult problem to salvage and those patients may not be salvageable, and end with an arthrodesis. Typically, at least in my hands, an arthrodesis after a failed surface replacement implant generally requires an autograft iliac crest bone block. I prefer to stabilize the arthrodesis with a 2.0 or 2.4 plate to span that entire construct.

DR. ADAMS: Dr. Renfree, since many surgeons would prefer not to fuse the MCP joint, what would you recommend for a failing pyrocarbon implant due to subsidence or loosening, especially if there is deterioration in range of motion? In other words, would you attempt an exchange using the same type of implant, remove it and convert to silicone, fuse it, or perform a soft tissue interposition?

DR. RENFREE: I think in that case, if you’re talking about the motion loss, shortening of the digit may play a role.

DR. ADAMS: Would you attempt another implant? Or remove it and convert to silicone? Or would you fuse?

DR. RENFREE: In a rheumatoid patient, I would not hesitate to fuse the MCP joint in the index finger, particularly if they have a failed silicone implant and recurrent ulnar drift. I would use the same technique as Dr. Murray mentioned – small bone block and fill the canals with graft after you curette them, and then use a mini-plate. By fusing the index MCP joint, it protects the ulnar 3 digits from the deforming pinch forces on the index finger and you can revise those MCP joints and give the patient a functional grip. A stiff fused MCPJ in the index finger isn’t so functionally disabling and I think will act as a post and prevent implant failure and recurrent ulnar drift of the other fingers if you revise those at the same setting, which is common. For failed MCPJ’s in general, especially when there is associated osteolysis, where it would be difficult to get a good press fit with a pyrocarbon implant, I would salvage with a cemented semiconstrained (metal and polyethylene) implant. The exception would be a poorly controlled or brittle rheumatoid patient, with whom I would be more inclined to use a silicone implant.

DR. BECKENBAUGH: Revisions are very difficult and usually have minimal success no matter what
you use in my experience. With resorbed and eroded medullary canals I believe cemented SR or pyrocarbon implants may be acceptable but most often in revision I end up debriding the medullary cavities and accept a limited result with silicone implants.

**DR. ADAMS:** For a failed PIP joint, my preference would be an arthrodesis, unless there was minimal bone loss in a low demand patient, in which case I would likely convert to a silicone implant. For the MCP joint, I nearly always plan to convert to a silicone implant.

Let’s move on to the CMC joint of the thumb. Dr. Renfree, do you stay completely with traditional soft tissue interposition or do you consider any of the newer implants?

**DR. RENFREE:** I have not tried any of the newer implants, like Artelon or the Pyrosphere. I have continued to utilize the trapeziectomy and ligament reconstruction. It’s been a predictable procedure in my hands, and is not associated with a high implant cost. So I haven’t felt the need to change. I have done hemi-trapeziectomy arthroscopically and then inserted allograft dermis in a limited number of younger patients, and had pretty good results with that. In that case it is important to look (arthroscopically) at the STT joint to make sure that pantrapezial arthritis is not present.

**DR. ADAMS:** Dr. Murray have you tried any of the newer implants or are you also maintaining the more traditional approach?

**DR. MURRAY:** I have tried a couple of different implants but I have almost exclusively relied on the traditional approach. I use the trapeziectomy and flexor carpi radialis sling suspension arthroplasty with some minor technical modifications. I’ve been pretty happy with the results of this procedure.

**DR. ADAMS:** My impression is the traditional approach is low risk and well known with predictable results but I must admit that I’m not thoroughly satisfied and I’m still looking for an implant arthroplasty that will provide quicker rehabilitation and more immediate pain relief as was seen early postoperative with silicone implants. My personal experience with the newer implants is limited to a ceramic spherical implant. My patients did quite well initially and up to five years regarding pain relief and range of motion. In fact, it seemed much better than my traditional interposition soft tissue arthroplasty. Unfortunately, there was a high rate of implant subsidence, particularly within the trapezium. So I have reservations about using other new implants. Certainly, there remains a lot of enthusiasm among surgeons and companies, using everything from biological materials to pyrocarbon to total joints. Although we need more clinical evidence to justify their widespread use, I would not condemn them.

**DR. BECKENBAUGH:** We have a very extensive experience with the pyrocarbon hemisphere implant. Initially, we had an unacceptable rate of dislocation but this has been eliminated by utilizing new techniques developed by Dr. Patterson (extensive metacarpal mobilization) in New York and Dr. Johnston-Jones (stabilizing trapezial metacarpal sutures) in Texas. We have prepared videos for both techniques. The ceramic sphere has now been also produced in the more physiologic pyrocarbon material and may offer success without subsidence but we do not know this yet. I am very enthused about joint replacement as compared to interposition arthroplasty. Thumb length is preserved, pinch strength is improved and function seems more physiologic. I agree with Dr. Adams that we need to keep an open mind in this. If we look at our suspension patients (which I have been doing happily for years) our patients are happy but their motion regresses to MCP hyperextension on careful exam and I think we can do better than that if we get a good implant. Only time will tell.

**DR. ADAMS:** Ulnar head implant arthroplasty has become a relatively popular treatment over the last several years, using a variety of designs. From a biomechanical standpoint there are many advantages over traditional partial or complete resection arthroplasties. In fact, the indications for implants seem to be growing.

Dr. Murray, do you use ulnar head replacements or do you stay with the more traditional complete or partial resections with some sort of soft tissue interposition?

**DR. MURRAY:** I really don’t have any experience with any prosthetic distal ulnar replacements. I’ve relied primarily on either bony reconstruction such as the Sauve-Kapandji or a soft tissue reconstruction such as the reconstruction that you described, the Adams/Berger reconstruction.

**DR. ADAMS:** Dr. Renfree, how about you, do you consider using an implant arthroplasty of distal ulna?

**DR. RENFREE:** Yes. I don’t typically use it as a primary procedure for distal radio-ulnar joint arthritis, particularly in the older patients in whom I would be inclined to use a more traditional procedure such as a Darrach resection, or Sauve-Kapange, arthroplasty. I have used a metallic ulnar head implant in younger patients with DRUJ arthritis (often post-traumatic), or in patients with symptomatic ulnar stump instability after either a Darrach or a Sauve-Kapandji procedure with success.
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DR. ADAMS: I began to use ulnar head replacement primarily for salvage of failed complete ulnar resections. Although I haven’t had 100% success regarding pain relief, I believe the functional recovery has been good and overall better than what I could achieve with more traditional approaches. In fact, I have been sufficiently encouraged to expand the indications to include primary treatment for osteoarthritis and posttraumatic arthritis, but very limited for the rheumatoid arthritis because of concerns for subsidence into the sigmoid notch due to poor bone quality.

There are several variations of implants now available ranging from partial head replacement that preserves most of the distal ulnar soft tissue attachments, to an unconstrained total joint that includes replacement of the sigmoid notch, to a constrained implant that restores the unstable distal radioulnar relationship and allows us to rehabilitate these patients almost immediately. Patient selection will remain very important when selecting the proper implants in order to match patient activity demand to implant durability.

DR. BECKENBAUGH: Richard Berger from our institution has been instrumental in “redeveloping” the concept of ulnar head replacement. He has clearly shown that there are significant problems with ulnar resection including a significant torque strength decrease. I believe ulnar head replacement for distal radial-ulnar disease will be commonplace in the near future.

DR. ADAMS: Mr. Brach, have you had the opportunity to rehabilitate patients following this recent excitement around ulnar head replacements?

MR. BRACH: Unfortunately I have not.

DR. ADAMS: Let’s finish by discussing what is perhaps the most controversial of all implants used in the hand and wrist, and that would be total wrist replacement. Its history has certainly been a rocky road dating back several decades, beginning with the silicone implant and progressing to a multitude of total joint designs. There are currently three designs available in the U.S. which show some convergence of design. Dr. Murray, what is your experience with total joint replacement, and can you describe your ideal patient which might be indicated?

DR. MURRAY: I have used several different designs, most recently I’ve used the SBI total wrist replacement, prior to that I had some experience with the Biaxial device. I think current designs now available have clearly improved. I think the indications are best in low demand patients with pain, yet relatively healthy and having bilateral disease. For me, infection or extensor or flexor tendon dysfunction limiting the ability to animate the prosthesis, would be relative contraindications.

DR. ADAMS: Dr. Renfree, what’s your indication for total joint replacement, and what are your specific contraindications?

DR. RENFREE: Again, I think pain has got to be the main indication whenever you’re considering a wrist replacement, simply because the wrist will function well if it is stable and painless. Having said that, I do feel more comfortable than I used to in recommending this procedure. With the newer generation implants, bone resection is minimal and cementation is usually unnecessary, so revision to a wrist fusion is not a real difficult salvage. Patients must be warned that it is a low-demand prosthesis, and I think a real contraindication would be dependence (present or anticipated) on walking aids.

DR. ADAMS: I think Dr. Murray and Dr. Renfree have summarized the important considerations surrounding wrist replacement that’s shared by the majority of surgeons. I might add that my experience over the past 15 years has led me to believe that the results parallel those found in other total joints with respect to the best candidates, in particular, patients with good bone stock, well balanced joints, good motor strength and control do better in all respects, including rehab, motion, and durability. Although traditionally wrist replacement was performed primarily for rheumatoid arthritis, these patients are often poor candidates for these reasons I just outlined. I have found the best outcomes in patients with osteoarthritis who have low activity demands.

Dr. Renfree mentioned his approach to salvage of a failed total wrist replacement. Dr. Murray, what other complications have you seen that would worry a surgeon considering the use of wrist replacement.

DR. MURRAY: Some of these complications may be device specific. You mentioned a distal component cutout problem, I have seen that complication with some designs. I’ve seen problems with instability or subluxation of the components, particularly in the less constrained designs. I have never seen an infection from a total wrist replacement. Distal radio-ulnar joint complications occur, particularly from either impaction or impingement, either with the prosthesis, impingement upon the prosthesis or impaction upon the distal carpal row. I’d be interested, Dr. Adams, to hear what you do with the distal ulna in an otherwise asymptomatic distal radial ulnar joint in a patient undergoing total wrist replacement. What
MR. BRACH: Obviously, my first thought would be, what are the goals that this patient has in mind after this procedure? And, are they realistic? Patient education is imperative after a procedure such as this. You have to be honest and up front with them. You have to tell them they’re not going to go back to playing golf or any other type of activity that involves a lot of wrist motion. The patient has to realize that this procedure is primarily for some type of salvage or pain control and that the wrist is not going to be a very high demand joint.

DR. ADAMS: Well, that puts us right at the top of the hour. Thank you taking part in this Hand Table discussion.

do you typically do with the distal ulna?

DR. ADAMS: In the osteoarthritic patient where the distal radioulnar joint is not involved, I believe the distal radioulnar joint does not need to be violated at surgery, which is easily allowed with proper technique using any of the currently available implants. If the DRUJ is also arthritic, then there are a few choices including ulnar hemi-resection with soft tissue interposition, ulnar head implant arthroplasty with total replacement or, my preference, partial head replacement. In very low demand patients or those with rheumatoid arthritis complete distal ulna resection is also acceptable. If you choose implant arthroplasty, there are two important factors to consider. First, the joint must be stable preoperatively, or it must be possible to effectively stabilize it at the time of surgery. Second, the integrity of the sigmoid notch must be preserved to avoid subsidence which could eventually lead to metal on metal where. Thus, I am less enthused about ulnar head implant arthroplasty in rheumatoid patients, who typically have poorer bone quality.

DR. BECKENBAUGH: We have some disagreement here Dr. Adams. The final word is still not out though. When we were doing stable perpendicular implant replacement of the wrist I NEVER saw a problem in an RA patient with a resected (Darrach) ulna. However, in the newer slanted prostheses, I think it is common and I frequently do simultaneous ulnar head arthroplasty in these patients, albeit with concerns regarding wear into the radius. The vast majority of patients with RA have distal ulna disease and it needs to be dealt with.

DR. ADAMS: Mr. Brach, what sort of questions would come to your mind in a patient presenting for rehabilitation following a total wrist replacement?