

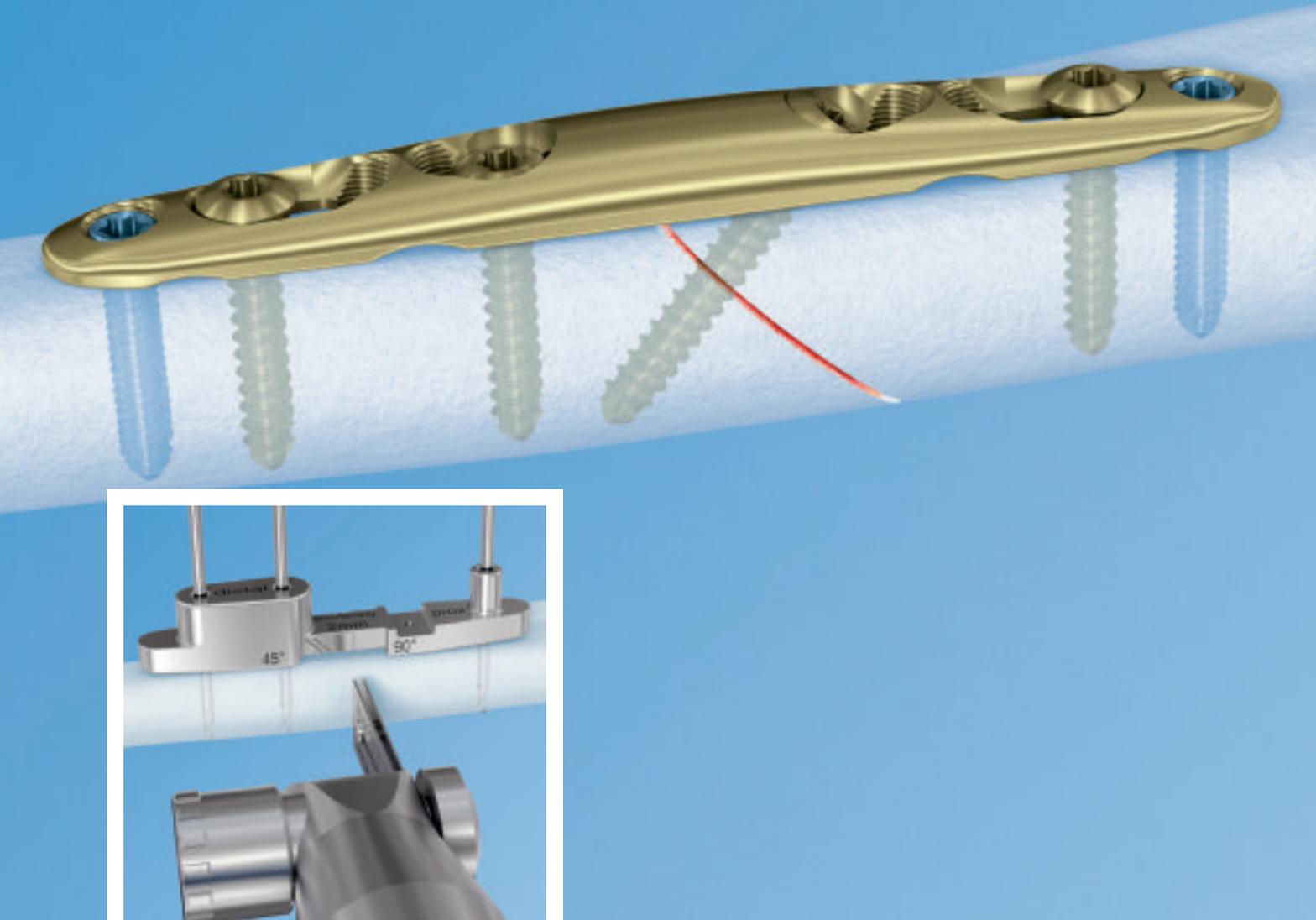
2013 IFSSH-IFSHT Triennial Congress overview



EVALUATION AND OUTCOME TOOLS FOR
ASSESSMENT OF UPPER EXTREMITY FUNCTION
IN CEREBRAL PALSY IFSSH REPORT

THERAPEUTIC
EXERCISE IN WRIST
REHABILITATION PART 1





Angular stable fixation of ulna shortening osteotomies.

LCP Ulna Osteotomy System 2.7.

Optimized Plate Design

The low profile plate with tapered ends reduces the risk of soft tissue irritation and hardware related patient discomfort. The plate is available in two lengths: 6 and 8 holes.

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System specific instrumentation like Parallel Saw Blades and Drill Templates allow to perform a secure and accurate osteotomy cut, for transverse cuts as well as for oblique cuts between 2 and 5 mm width.

Freehand Technique

Additionally available Compression/Distract Instrument to facilitate freehand technique application especially in shortenings more than 5 mm.



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12th IFSSH and 9th IFSHT Congresses, New Delhi, India, 4–8 March 2013

The triennial IFSSH Congresses serve a number of important purposes. Apart from sharing new information and personal experience, we also interact, to form new acquaintances. Furthermore, we catch up on the doings of the Federation, and get updated on the current state of Hand Surgery and Hand Therapy worldwide.

Since its inception in 1966, the IFSSH has grown from eight Member Societies, to 55 presently. Four regional Hand Surgery Federations have come into existence viz. the European, the South American, the Asia Pacific, and the North and Middle American Federations. Most importantly however, we have formed an essential and integrated working relationship with the Hand Therapists through their Federation, hence the combined triennial Congress of the International Federation of Societies for Surgery of the Hand, and the International Federation of Societies for Hand Therapy.

Apart from all the activities by these five Federations, and their National Member Societies, it is indeed heartwarming to see more and more Hand Surgeons

and Hand Therapists all over the world working untiring, through outreach programmes, and personal sacrifice, giving so much of their time and expertise, to better the care and welfare of patients' hands.

During my term as President of the IFSSH, my aim was to further advance this Federation as the 'integrating organisation' for Hand Surgery internationally. Some changes were made, to improve mutual understanding, sharing and standardisation. Let me mention only three:

Firstly, we wanted to improve communication amongst all our Members, including the Hand Therapists, and even non-medical persons who have an interest in the well-being of the Hand. The *IFSSH ezine*, an electronic magazine, was launched in February 2011. It is published, free of charge every three months, and sent to over 10,000 individuals and organisations. It contains all kinds of helpful and relevant information, as well as the Reports from the Scientific Committees. The aim of the Ezine is to be a communication tool *for* our members, and *by* our members, in order to *share* common interests. So please

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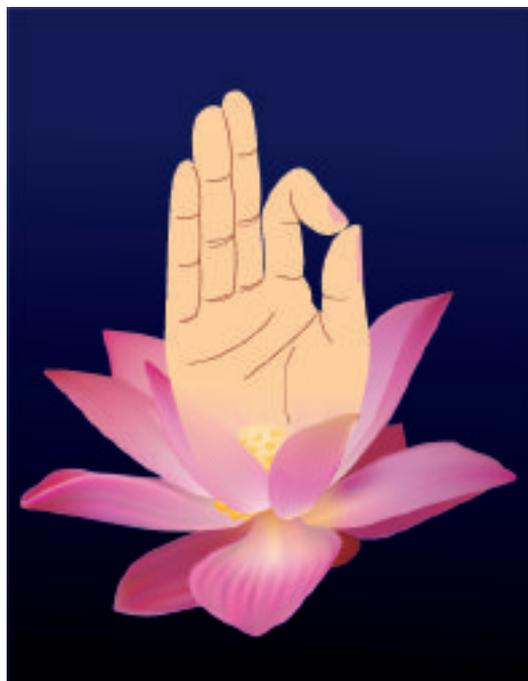
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(President of the IFSSH)

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IFSSH & IFSHT INDIA 2013

feel free to write and contribute to *your* magazine. All National Delegates receive the Ezine, and are requested to forward this magazine to all their individual Society Members. But, any person who still does not yet receive this electronic publication is of course welcome to subscribe on an individual basis. This will ensure that you will receive your copy immediately and directly from the publisher.

Secondly, the *Scientific Committee System* was radically overhauled with the help of President-Elect Michael Tonkin. New guidelines have been set. Many more Members are now involved, producing more, specific and relevant Reports, not only every three years, but on an ongoing basis. Once these Reports are submitted to the President, they are published in the IFSSH ezine, and then posted on the website. Since they represent the views of a panel, the contents could be seen as representative of the current 'state-of-the art' of hand surgery and therapy. Presently, more than 25 Committees are working on allocated topics. We thought that since so much good and dedicated work is being put into these Reports, hard copies for future reference is prudent, and will be made available at future Congresses.

The third development, is the establishment of the *Committee for Educational Sponsorship* under the Chairmanship of Secretary-Elect Marc Garcia-Elias. Over

the years, especially under the leadership the previous Secretary-General and President James Urbaniak, the financial position of the IFSSH is such, that it has now accumulated enough funds, to enable the establishment of Financial Sponsorships. Guidelines for applications are being finalised, and will be available on the IFSSH website. Members are encouraged to make use of these generous grants. These Educational Sponsorships can take many forms. For example, a recent project was a Lecture and Cadaver Workshop in Hungary, which involved 130 surgeons from 14 countries.

With these and other changes we have noticed more integration amongst our members internationally. We know more about each other's activities worldwide, and are therefore more exposed to new and helpful ideas, exciting innovation, and by engaging in these activities, pushing Hand Surgery standards constantly to new levels.

When the IFSSH was established, the emphasis was very much on Hand Surgery, being performed by Hand Surgeons. However, a welcome and mutually beneficial change has occurred during recent times regarding the irrevocable realisation that surgery is not the only method to manage hand conditions. Optimising the management of ailments and differences of the Hand, involves a more comprehensive approach. *Hand Therapy* has added a new dimension to regain form and function. Splinting, and

all manner of rehabilitation, has become a highly skilled specialty, hence our close working relationship with Hand Therapists.

It may be discerning to remember the wise words of Christian AT Billroth (1829-1894), Professor of Surgery in Vienna, Austria who defined a surgeon: "A surgeon is a doctor who knows when not to operate". This attitude should always be in the back of our minds when seeking a solution to a clinical problem. All ailments and differences cannot, and will not necessary, be solved by surgery. Nowadays we have so many more modalities to fulfill the aims of the our Charter. It may therefore be more correct to call ourselves *Hand Specialists*, rather than Hand Surgeons!

Our Historian, Frank Burke has done sterling work in soliciting archival material of the IFSSH. Currently he is selecting relevant documents to be scanned and stored electronically on the website. The advantage will be that anybody can then access the historical information. He will also seek a permanent location, for some important artifacts of historical significance.

Secretary-General Zsolt Szabó has been running the Federation efficiently and professionally. His energy has been second to none and this, while also running FESSH, amongst others, and organising the very successful Eastern European Hand Course mentioned above.

I would like to use this opportunity to sincerely thank all the *Executive Members*, for their unselfish, enthusiastic and willing contributions during the past three years, to make our International Federation work smoothly as a dynamic organisation. Each one covered his task with notable distinction, and their portfolio Reports will be tabled at the Delegates Council Meeting. Of course, many more willing volunteers contribute to the successes of the IFSSH. In particular I would like to mention all the *Scientific Committee Chair persons and their Committee Members*. We all know the substantial amount of work it takes to prepare a Report. Thank you so much.

Our Federation is now a well-oiled organisation, and which is still gaining momentum. Having a *permanent, centralised Administrative Office*, adds to the professional functioning of the Federation. Our administrator, Belinda Smith, is indeed exceptional, not only for being efficient, capable and innovative, but also so pleasant to work with! Thanks, Belinda.

And finally a very sincere word of thanks to Professor Raja Sabapathy, and his amazing team, who have worked so hard to get everything ready for the *12th IFSSH Congress* in New Delhi, so that we, the participants, could enjoy an exciting, and an enriching hand surgery, and cultural experience. The fact that the registrations have reached a record number, speaks to their tremendous organisational effort. You have done a phenomenal job. Congratulations!



Ulrich Mennen
Immediate Past-President:
International Federation of Societies for Surgery of the Hand
Editor: IFSSH ezine

Obituaries

Dr. James H. Roth

During the night of January 31-February 1, 2013, Dr. James H. Roth unexpectedly passed away.

Jim Roth graduated from the University of Western Ontario Medical School in 1975. During his University days, Jim played football for the University's Mustangs and was a feared and competitive athlete. He graduated from Western's School of Medicine in 1975 and continued his clinical orthopaedic training in London. During his orthopaedic surgery residency he spent one year as Dr. J.C. Kennedy's research resident. Post-residency Fellowship was completed in Hand and Microsurgery at Duke University Medical School prior to starting practice at Victoria Hospital in London, Ontario on January 1, 1982.

In 1988, he became a full professor at Western. In January of 1992, Jim moved to St. Joseph's Health Centre in London and together with Dr. Bob McFarlane, he established the Hand and Upper Limb Centre (HULC). Under Jim's guidance and mentorship, HULC has grown into the largest upper extremity surgical centre in Canada and mostly because of Jim's vision, the unit was able to establish itself as one of the premier centres in the world for upper extremity clinical care, research and teaching. Jim trained countless residents and since 1992 has trained more than 80 Fellows who are practicing all around the world. Jim authored more than 150 scientific papers and book chapters and has treated tens of thousands of patients.

The IFSSH will always owe Jim for the hard and dedicated effort he has put into organizing the Seventh Triennial Congress of the IFSSH in Vancouver, Canada, in 1998.



Jim leaves a legacy of excellence in clinical care, teaching, research and academic administration. He was long-time married to his wife Barbara and a proud father to four fiercely independent and successful daughters. His two grandchildren gave him immeasurable pleasure.

Jim was the epitome of success in his personal, athletic, organizational and academic pursuits.



Variable angle locking technology for mediocarpal partial arthrodesis. VA-Locking Intercarpal Fusion System 2.4.

Low profile plates

The plates are especially designed for fixation of four corner arthrodesis and feature a low profile design with rounded edges to minimize the risk of soft tissue irritation. They are available in two sizes (\varnothing 15 mm/6 holes and \varnothing 17 mm/7 holes) and have K-Wire holes incorporated to allow temporary fixation of the plate.

Variable angle locking technology

The 2.4 mm variable angle locking screws can be angled up to 15° off axis and provide a strong angular stable construct. Also, 2.4 mm Cortex screws can be used to apply compression.

Innovative Instrumentation

System specific instruments like Reduction Reaming Guides additionally support the surgeon during procedure. The fusion site is fixed during the whole procedure and if desired, compression can be applied with the instrument.

Letters to the editor

EDITOR: *In the previous IFSSHezine we asked you to send us analogies or ways how you would describe in layman's terms, conditions or procedures to patients. The following letter was received from a reader:*

Dear Editor,

Symptom intensity and magnitude of disability correlate most strongly with coping strategies (e.g. mindset), so it's important to use analogies that give patients optimism and self-efficacy, overcoming the natural tendency for protectiveness and preparation for the worst in response to symptoms, pain in particular. In that spirit, I use some different analogies than those that were listed.

- De Quervain's: "We have many tunnels to hold tendons and nerves in place. Just like loose joints and tight joints, some of us have tighter tunnels. If you have a tight tunnel eventually the nerve develops problems."
- Tennis Elbow: "Tennis elbow is like the graying and thinning of my hair-expected with age. But unlike arthritis, this will not hurt forever. It tends to run its course in about 12 months plus or minus 6 months." (The graying and thinning analogy is good for rotator cuff tendinopathy and trapeziometacarpal arthrosis as well).
- Ganglion Cyst: "Since 50% of normal wrists have a ganglion cyst, we can consider these little pockets as little side effects of the normal process of lubricating a joint".

- Scar Tissue: "Think of the scar tissue like this piece of cloth. If I pull it long enough, the fibers will relax to a longer length."
- Arthritis: "Arthritis of the base of the thumb is like grey hair-everyone gets it. My hair isn't graying and thinning because my hat is too tight or my pillow is faulty - it's the normal development of the human body".
- SLAC and SNAC wrist: "The scaphoid is the keystone to the wrist and when it fails the entire wrist collapses." "The wrist is like a set of ball bearings. If one is a little out of place the joint may wear a little quicker."

David Ring, MD PhD

Read the previously published list of analogies here
Can you think of more analogies? Send them to us at ezine@ifssh.info

Address of Incoming IFSSH President Michael Tonkin

Closing Ceremony, IFSSH Congress, Delhi 2013

Photo: Michael Tonkin

Ulrich, Ladies and Gentlemen,

I am honoured and daunted by the privilege you have bestowed upon me. In this address I have three tasks, the first of which is a delightful pleasure – that being to acknowledge the contribution of IFSSH President, 2010-2013, Ulrich Mennen. No previous IFSSH President has been more determined, more involved, or demonstrated greater leadership during his term of office. His close associations with Secretary-General Zsolt Szabo, the IFSSH Executive Committee and Secretariat have led to an optimal coordination of IFSSH activities. The establishment of the IFSSH ezine is entirely due to the efforts of Ulrich. This has become a communication vehicle for the Federation, reaching over 10 000 subscribers, and is perhaps one of the most effective methods of bringing the hand surgery world together. He has revamped the IFSSH Scientific

Committees, leading to an orderly presentation and publication of these committee reports, and established a structure ensuring the worth and continuity of reports with publication in the ezine, on the IFSSH website, and within a special booklet to be produced at each IFSSH Congress. Ulrich, along with Zsolt, established a relationship with the Russian Society for Surgery of the Hand which led to the successful application of the Russian Society as a member society. The Bolivian Society has also joined our family and the combined Scandinavian Society is now represented by its individual four societies: Denmark, Finland, Norway and Sweden. Ulrich gave of his time to instruct in invaluable regional courses in Hungary and Russia, fulfilling a basic tenet of our Charter.

Ulrich, South African by birth, has been a contributor at all levels, local hospital and district, national and

international levels. He is a serious and studious man but despite the worth of his contributions, these alone do not define the substance of the man: to understand him is to know Ulrich the sportsman, to know the humour of the man, the friendship of the man and the devoted family man, husband of Jo and father of three impressive children.

Ulrich steps down from the Presidency but as Immediate Past President he remains an active member of the Executive Committee. He chairs the Nominating Committee and, as for Napoleon after any successful campaign, the challenges remain ahead. Ulrich, thank you and please accept this certificate in acknowledgement of your term as President of the International Federation of Societies for Surgery of the Hand.

My second task is to announce the 2013-2016 Executive Committee.

Zsolt Szabo is our President Elect,



having completed a very impressive term as Secretary-General in a successful partnership with President Ulrich Mennen. Zsolt is as enthusiastic and energetic a person as the convenor of our current Congress, Raja Sabapathy – few have such energy. As Secretary-General, he managed the day to day affairs of the Federation with minimal fuss and maximal efficiency, organised the Eastern European Hand Surgery Course in Hungary, joined Ulrich in meeting with the Russian Society and teaching at Russian Society courses, and has been instrumental in establishing the future official framework of the IFSSH as a charitable organisation with its

“These teachers, amongst many others, inspired a passion for teaching and it is this which I believe I can offer to the International Federation as President over the next three years”

bank account housed in Switzerland. He is a very worthy President Elect. I am delighted to present Zsolt with his official certificate to acknowledge his contribution as Secretary-General.

Marc Garcia-Elias moves to the Secretary-General position. No President could wish for a better colleague as Secretary-General. Although the sophistication of the tasks of Secretariat and Executive Committee members have increased, the Secretary-General position remains the engine room of the Executive Committee of the Federation.

Daniel Nagle, a past President of the American Society, joins us as Secretary-General Elect.

Ulrich Mennen moves to the position of Immediate Past-President.

We are fortunate that we retain the wisdom and common sense of our IFSSH Historian, Frank Burke, who has been responsible for collecting, collating and documenting the archives of the Federation and committing them to an electronic file – a substantial undertaking.

Lastly, I would welcome Moree Beppu from Japan to the appointment of Member-at-Large. This is an important position, providing as it does a member from the Delegates' Council to assist the three most recent Past-Presidents in their roles as members of the Nominating Committee, responsible for the assessment of nominated Pioneers and the nomination of Executive Committee members.

My final task is to address you as incoming IFSSH President. This is difficult. I looked to the experiences of the five previous IFSSH Presidents: Yasuo Yamauchi (Japan, 1998-2001), Guy Foucher (France, 2001-2004), Arlindo Pardini (Brazil, 2004-2007), Jim Urbaniak (USA, 2007-2010) and Ulrich. These are all dignified, elegant and impressive men. In comparison, I feel wanting. My wife has informed me that no matter what form of dress, no matter how I comb my hair, or even if bald, I will never appear either dignified or Presidential. In considering the geographic spread of the previous five Presidents, perhaps there is an improved symmetry to the world map if an Australian is invited to the position of IFSSH President and our Federation is reintroduced to the exotic residents of Australia – the



“we are responsible for disseminating knowledge of hand surgery; we should support the development of hand surgery in underdeveloped countries; and we should foster friendship between nations and individuals.”

kangaroo, the platypus, the koala and kookaburra amongst others. I say ‘reintroduced’ as Bernard McC. O’Brien from Melbourne was IFSSH President from 1980 to 1983. He was a towering figure in the worlds of hand surgery and microsurgery and one who was lost to us at far too young an age, as he had so much more to contribute.

In anticipating the course of my term of office, I ask myself what I have to offer. I considered the recent contributions of Jim Urbaniak and Ulrich Mennen. Here I pause to acknowledge the outstanding service of Jim Urbaniak to the IFSSH. He has been part of the Executive for 18 years and, during that time, he has become the current father of the IFSSH, the one to whom we all turn for advice, particularly when there are ticklish problems confronting us. These problems are always met with wise words and a gentle smile. Jim achieved a remarkable feat during his Presidency, that being to produce a magnificent book entitled “Hand Surgery Worldwide” which contains the history of each of the 50 member societies of the IFSSH, along with a number of classical clinical and scientific articles. Jim will remain with us as a member of the Nominating Committee and we welcome his continued presence. I have discussed the achievements of Ulrich Mennen. In comparison with these two, I regret that I don’t have a single project which will define my Presidency, a mission or a vision. I feel a little like the boy, or one of the two dogs depicted in this picture in which the three are isolated on a seat in the centre of a flooded river.

I reflect upon the IFSSH Charter. Article 3 describes the aim of the Federation, the chief purposes of which are detailed in 11 principles. I summarise these in the following manner: we are responsible for disseminating knowledge of hand surgery; we should support the development of hand surgery in underdeveloped countries; and we should foster friendship between nations and individuals.

The first of these purposes - teaching - caused me to remember my own teachers. Bill Lennon, an orthopaedic surgeon from Sydney, will be unknown to most in this room. However, it was he who first inspired my fascination with and devotion to the field of hand surgery. Frank Burke continued this during my hand surgery fellowship in Derby. One of his teachers, Adrian Flatt, was a teacher from afar through his writings and I covet the memorable occasions on which we meet. I spent 12 months in Louisville in 1984 at a time of great excitement during the development and application of microsurgical techniques to hand surgery. I am indebted to Harold Kleinert and his group. Specifically, Graham Lister was the most superb didactic teacher I have encountered. The precision of Dieter Buck-Gramcko's teaching of congenital hand surgery drew me to this field of hand surgery, for which I am ever grateful. I consider Eduardo Zancolli Sr to be one of two geniuses of orthopaedic surgery whom I have met, the other being Sir John Charnley. His knowledge of anatomy and application of an innovative mind to the surgery of patients afflicted with

cerebral palsy, rheumatoid arthritis and tetraplegia were the basic pillars of my hand surgery learning.

These teachers, amongst many others, inspired a passion for teaching and it is this which I believe I can offer to the International Federation as President over the next three years. It may also be applied to the second purpose of supporting the development of hand surgery, particularly in underdeveloped countries. The IFSSH Executive Committee, through its Committee for Educational Sponsorship, has identified the following four areas worthy of receiving both financial and teaching support:

- 1) Special education projects, such as the production of the IFSSH Terminology booklet and the "Making a Thumb" DVD; the funding of fellowship projects such as that at Baragwanath Hospital in South Africa; and the support of affiliated groups such as the International Federation of Societies for Hand Therapy.
- 2) The second component of support is that for individual society congresses and courses, through provision of speakers, support of registrations, and provision of equipment where appropriate.
- 3) Thirdly we can assist in the organisation of regional courses such as the Eastern European Hand Course held in Hungary in 2012, through the provision of teachers and the support of registrants' fees.
- 4) Fourthly, we will continue the financial support for financially disadvantaged surgeons to attend IFSSH Congresses.

I commend these projects to you. All societies should consider how they may be involved.

Finally, the third purpose: we are not isolated as individuals or as stand-alone societies. Our international friendships allow us to understand and assist in solving the problems of others. The triennial congress and the interaction between societies through the ezine, the website and projects listed above, allow people from all parts of the world to communicate and to contribute. I look around at the members of this audience and am appreciative of what a wonderful privilege this is.

Ladies and gentlemen, we have attended a marvellous congress. We should be grateful to the Indian Society, Raja Sabapathy, his committees and all included in the congress organisation, for an outstanding achievement. I encourage all of you to support Eduardo Zancolli Jr and the Argentinian surgeons and therapists by joining together again in Buenos Aires in 2016.

IFSSH-IFSHT Triennial Congress overview

The 12th IFSSH and 9th IFSHT Congresses took place in New Delhi, India, from 4 – 8 March 2013. The IFSSH ezine asked a number of delegates to share their experiences of the Congress with the readers. In addition, we also include a selection of photos that capture the essence of the Congress.



It was a pleasure seeing everyone in the meeting. A big thumbs-up to the organizing committee for a well organised meeting. I would especially commend to the organisers of the programme for having a good balance of pioneers and innovators of the field. I went home with more questions than answers, which is always a good feeling. My only regret was missing some talks because I had to choose among several good ones.

As a young practitioner, I have everything to gain in attending the IFSSH congresses. I will definitely encourage more colleagues to join me in the future.

Nathaniel S. Orillaza Jr., MD, Clinical Associate Professor at the College of Medicine at the University of the Philippines in Manila.

The brotherhood of hand surgeons worldwide still consists of a relatively small group of people, especially when compared with other medical specialties. No wonder that over the years more than a professional friendship has developed among many colleagues! The triennial congress of the IFSSH is a unique opportunity to come together and collect stimuli how to improve one's own practice and discuss new ideas. The cycle of three years between meetings ensures that true changes in knowledge become apparent in the contributions.

The IFSSH Congress is a great opportunity to communicate with colleagues of the world, but also to meet old friends and make new ones. As in former years, the officers of the Federation and especially the local hosts had to invest a tremendous amount of work to make this year's congress in New Delhi as informative and, at the same time, as pleasant as it was. The work of all of them is highly appreciated and we all express our sincere thanks. The fact that the meetings are held in different cities in many different countries also gives us the opportunity to

learn more about the country, its people and cultures. So far and in the next future the location of the congresses were spread over all continents of the world – except Africa and Antarctica. Save the latter, an African city should be seriously considered for one of the future meetings.

Ulrich Lanz, Munich, Germany

Ulrich Lanz (centre) Awarded "Pioneer of Hand Surgery" in Delhi with wife, Heide, and Prof Gus McGrouther (UK)



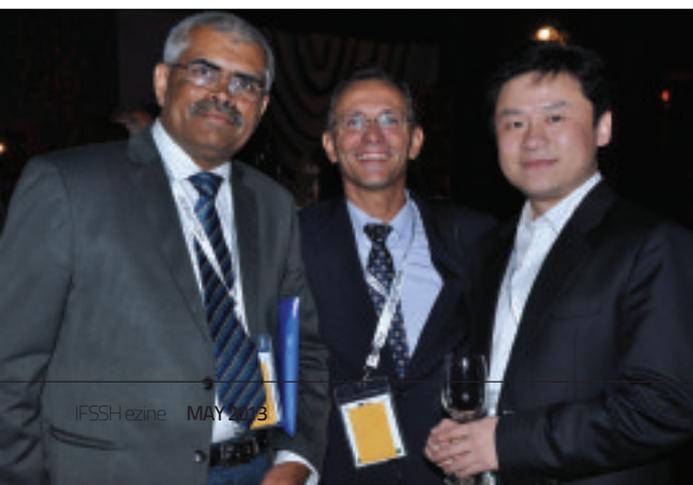


RIGHT: Dr Raja Sabapathy, Chief Organiser of the IFSSH Congress lights the symbolic candle



"As a young practitioner, I have everything to gain in attending the IFSSH congresses." Nathaniel S. Orillaza Jr, Philippines

"The meeting provides a great venue for not only education, but also gives you the rare opportunity to interact and form relationships with surgeons from many other countries." Scott Oishi, USA



The IFSSH congress was a great opportunity to catch up with friends and colleagues from the other side of the world. The symposia, in particular, gathered a broad range of experts with different viewpoints on many of the difficult problems in Hand Surgery.

David McCombe, *Royal Children's Hospital, Melbourne and Victorian Hand Surgery Associates, Australia*

Along with the joy of returning to a congress to meet up with overseas friends, there are invaluable learning opportunities. At the Delhi meeting, the sessions were all of a good quality. Exceptionally entertaining was the congenital hand session, in which acknowledged Hand Surgeons 'battled' on several subjects. Their thoughts will be very valuable in decision making for daily practice. The dinner after the opening ceremony was very enjoyable, not only because of the food, but especially because of the ease in which you could meet colleagues. I would absolutely encourage colleagues to attend the IFSSH Congresses. It has an easy accessible atmosphere where experts in their field are willing to have good and constructive conversations.

Christianne van Nieuwenhoven, *Erasmus MC, University Medical Center, Rotterdam, The Netherlands*



The overall quality of the scientific programme was excellent, with great speakers that made you want to get out of bed early in the morning and lively discussions until the end of the day.

I enjoyed the congenital debate session the most. I felt that the problems were presented in a comprehensive way by all speakers, they were clearly and concisely answered by the respective debate-partners and Professor Tonkin did a terrific job as moderator by capturing the essence of every discussion in a critical question or a precise summary.

The evening dinners were the best. Nice ambiance, great service and the food was simply delicious!

Everyone interested in hand surgery should visit the IFSSH Congress. It is a great opportunity to get updated on the state of the art, share ideas, develop new collaborative projects that push present boundaries and enjoy the company of colleagues in a non-clinical setting.

Robert Dijkman M.D., *Dept. Plastic and Reconstructive Surgery and Hand Surgery, Erasmus MC, University Medical Centre, Rotterdam, The Netherlands*



I would definitely encourage hand surgeons from

all countries to attend the IFSSH Triennial Congress. The meeting provides a great venue for not only education, but also gives you the rare opportunity to interact and form relationships with surgeons from many other countries.

Scott Oishi, *Texas Scottish Rite Hospital for Children, Dallas, Texas, USA*

Indian travel tip – Ulrich Mennen

After the successful 12th IFSSH Congress in New Delhi in March, we travelled south to visit places of interest. In Mumbai we treated ourselves by having Indian cuisine in a smart and upmarket restaurant run by a well-known chef who published his own cookbook.

We ordered Lamb Curry. After placing our selected dish, the following conversation took place

between myself and the waiter:

“Could I ask you a question to clarify an uncertainty? What is the definition of the words “mutton” and “goat” in India? I ask this question because I have seen both on the menus all over India”

“Same thing, Sir”

“You mean, if I order lamb, I may get goat?”

“Most certainly, Sir”

“Why?”

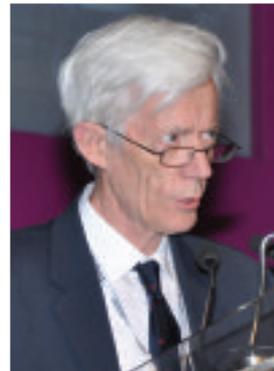
“Because in India sheep is very rare. In India sheep is goat, and goat is sheep.

It's like chicken, Sir, it could also be duck. Same difference.

But, Sir, you will find it very tasty and soft, because we only use the small ones.

And, Sir, the spices compliment the taste.

I am sure you will enjoy your food”



LEFT: Professor Wayne Morrison from Melbourne, Australia, presented the honorary Swanson Lecture

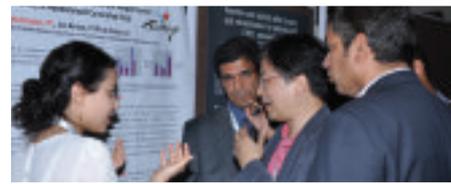
"The overall quality of the scientific programme was excellent, with great speakers that made you want to get out of bed early in the morning and lively discussions until the end of the day."
Robert Dijkman, the Netherlands



"The symposia, in particular, gathered a broad range of experts with different viewpoints on many of the difficult problems in Hand Surgery." David McCombe, Australia

"It has an easy accessible atmosphere where experts in their field are willing to have good and constructive conversations"
Christianne van Nieuwenhoven





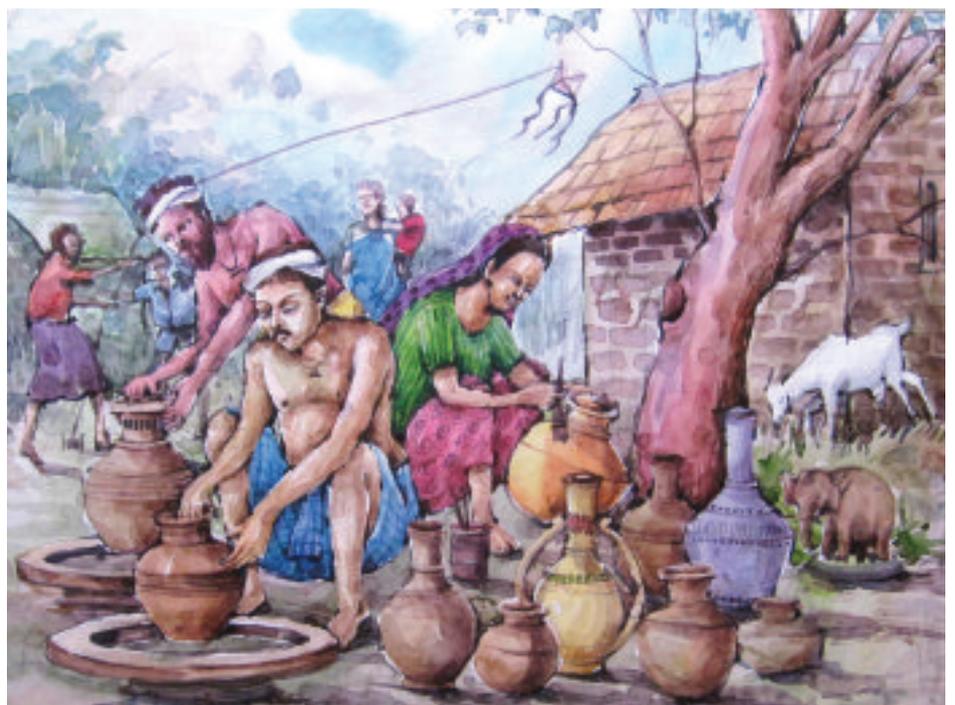
"The cycle of three years between meetings ensures that true changes in knowledge become apparent in the contributions."

Ulrich Lanz, Germany



Putting young hands to work

In the lead up to the IFSSH-IFSHT Triennial Congress an art competition was held for school children around India. Themed 'The Magic of Hands' the competition invited schools to submit paintings on this topic. Over 2000 schools submitted 4250 entries. The top 50 paintings were selected and compiled into a coffee table book. The winning painting, titled: 'A lump of clay in the potter's hand is tomorrow's earthenware' was painted by Master Midhun P.P., Class IX, Azhikode School, Kannur, Kerala, India.



Evaluation and outcome tools for assessment of upper extremity function in Cerebral Palsy

IFSSH Report

Cerebral Palsy Scientific Committee:

Ann Van Heest MD, Michelle James MD, Michelle Gerwin Carlson MD

Cerebral Palsy is a group of disorders of development of movement and posture that cause activity limitations attributed to non-progressive disturbances of the developing fetal or infant brain (1). The primary problem in cerebral palsy is a central nervous system (CNS) insult which leads to

secondary muscle imbalance, resulting in joint malpositioning and functional impairment of the upper limb. This can lead to tertiary problems of muscle contracture, joint contractures and skeletal deformity.

This report examines the evaluation

and outcome tools for assessment of upper extremity function in cerebral palsy. Evaluation of upper extremity function includes defining the degree of disability in use and function of the upper limb. The World Health Organisation (2) defines disability



as causing bodily impairment, activity limitations, and participation restrictions. Impairment is a problem in body function or structure. An activity limitation is a difficulty encountered by an individual in executing a task or an action. A participation restriction is a problem experienced by an individual in involvement in life situations. Thus, disability is a complex phenomenon interaction between features of a person's body and the features of the society in which he or she lives. Disabilities encountered in children with cerebral palsy encompass impairments of bodily function, activity limitation and participation restrictions. Assessment of upper extremity function ideally would measure disability in all three realms, in addition to the dimension of quality of life. Traditionally, assessment has primarily focused on bodily function, but more recently assessment has also included activity limitations and to some extent, participation restriction.

Assessment of the upper extremity in cerebral palsy always includes

measures which are used for standard upper extremity function assessment including active and passive range of motion as well as grip and pinch strength testing. Hand function tests that are not specific to cerebral palsy can be used for assessment of hand function, such as the Jebsen-Taylor hand function test, the 9-hole peg test, and the box and blocks test. For the higher functioning child, each of these can be useful for assessment of unilateral hand function. This report would like to outline those assessment tools which are specifically designed for cerebral palsy and provide references for the practitioner desiring more in depth testing information.

The House upper extremity assessment (3) is a 9-point scale that describes the use of the affected arm during activities (Table 1). This classification was designed specifically for cerebral palsy and describes use of the limb ranging from "does not use" (level 0), to full spontaneous use (level 8). More recently, the Manual Abilities Classification System (MACS) has been designed as a classification of manual

ability (Ref 4) in children with cerebral palsy age 4 – 18 years. MACS assesses the child's ability to handle objects in important daily activities such as play, leisure, eating and dressing. As shown in Table 2, MACS scores a child as level 1 (handles objects easily and successfully), to level 5 (does not handle objects and has severe limited ability to perform even simple actions). The MACS gives an overall picture of the child's ability to use the hands in daily life, including the influence of cognitive problems. The classification supplements the Gross Motor Function Classification (5) in giving a general description of motor function in the child with cerebral palsy. Similar to the House scale, the MACS classification system provides a general description of upper extremity use during activities of daily living.

The Shriners Hospital Upper Extremity Evaluation (SHUEE) (6) has been used specifically for assessment of the upper extremity in cerebral palsy. This test has five sections, including: active and passive range of motion, activities of daily

Table 1: House Upper Extremity Functional Use Classification

Class	Designation	Activity Level
0	Does not use	Does not use
1	Poor passive assist	Uses as stabilizing weight only
2	Fair passive assist	Can hold onto object placed in hand
3	Good passive assist	Can hold onto object and stabilize it for use by other hand
4	Poor active assist	Can actively grasp object and hold it weakly
5	Fair active assist	Can actively grasp object and stabilize it well
6	Good active assist	Can actively grasp object and then manipulate it against other hand
7	Spontaneous use, partial	Can perform bimanual activities easily and occasionally uses the hand spontaneously
8	Spontaneous use, complete	Uses hand completely independently without reference to the other hand

living, spontaneous use functional analysis, grasp and release, and dynamic positional analysis. The range of motion measurements include shoulder, elbow, forearm, wrist, hand, finger and thumb as well as an assessment of modified Ashworth scale (0 – 4) for tone analysis during range. The activities of daily living section analyses seven activities and grades the patient as independent, dependent or assist. The spontaneous functional analysis is an examination of nine different activities, assessing spontaneous use of the affected arm using a modified House scale (6-point scale, from “does not use” to “spontaneous use”). The dynamic positional analysis analyses five different segments (thumb, finger, wrist, forearm and elbow) and describes the position of the segment during 16 different activities. For example, the thumb segment is described as either across the palm, closed, next to the index finger, or open. The finger segment is assessed as in flexion, neutral or extension and similarly the wrist segment in

“recent advances in cerebral palsy have included development of disease specific validated evaluation and outcomes tools”

flexion, neutral or extension, and the elbow segment in extreme flexion or extension, while the forearm section is extreme pronation, pronation neutral or supination. The grasp and release analysis looks at the ability to grasp and release the object when the wrist is in three different positions: flexion, neutral and extension.

Other methods of functional assessment specific to cerebral palsy include use of video analysis. First

validated by Waters (7), observation of daily activities have been shown to have both intra- and inter- observer reliability. Additionally, Carlson (8) has shown that changes were made to initial pre-surgical plans on over 70% of patients after video tape evaluation. This was most common for surgical procedures addressing the wrist, digit and thumb, pointing to the fact that these can be dynamically assessed using video analysis and that this video analysis leads to different conclusions than that which may be seen in an office setting.

The Melbourne Assessment of Unilateral Upper Limb Function (9) is a validated, standardised test for measuring affected limb function in children aged 5-15 years with unilateral cerebral palsy. Children are videotaped performing 16 test activities of grasp, release, reach, and manipulation. The videotapes are scored for qualities of movement range, accuracy, fluency, and dexterity. More recently, a modified Melbourne assessment for ages 2-4 has been developed (10).

Table 2. Manual Ability Classification System (MACS)

MACS Level of Ability	Description
Level I	Handles objects easily and successfully. At most, limitations in the ease of performing manual tasks requiring speed and accuracy.
Level II	Handles most objects but with somewhat reduced quality and/or speed of achievement. May avoid some tasks or use alternative ways of performance.
Level III	Handles objects with difficulty; needs help to prepare and/or modify activities.
Level IV	Handles a limited selection of easily managed objects in adapted situations. Requires continuous support.
Level V	Does not handle objects and has severely limited ability to perform even simple actions. Requires total assistance.

Further elaboration of use of the video has been described by Van Heest (11). Using motion lab facilities with the use of split screen videos, biplanar assessment of dynamic deformity can be assessed. Additionally, dynamic electromyographic assessment of muscle function can be simultaneously collected to further evaluate deforming forces of spastic or flaccid or dystonic muscle patterns. The patterns of muscle firing can be used for assessment for tendon transfer surgery.

Many of the functional analyses examine the affected hand in cerebral palsy with forced unilateral function in a controlled test situation. The

Assisting Hand Assessment (AHA) is a major advancement in upper limb assessment in CP because it allows grading of the ability of the affected hand to serve as an assist for bimanual tasks in spontaneous activities (12). The AHA was designed for unilateral conditions such as brachial plexus birth palsy and unilateral cerebral palsy. The AHA evaluates how effectively the affected hand and arm is used in bimanual performance and the assessment is made by observing the child's spontaneous handling of toys in a relaxed and playful session.

In summary, recent advances in cerebral palsy have included development of disease specific

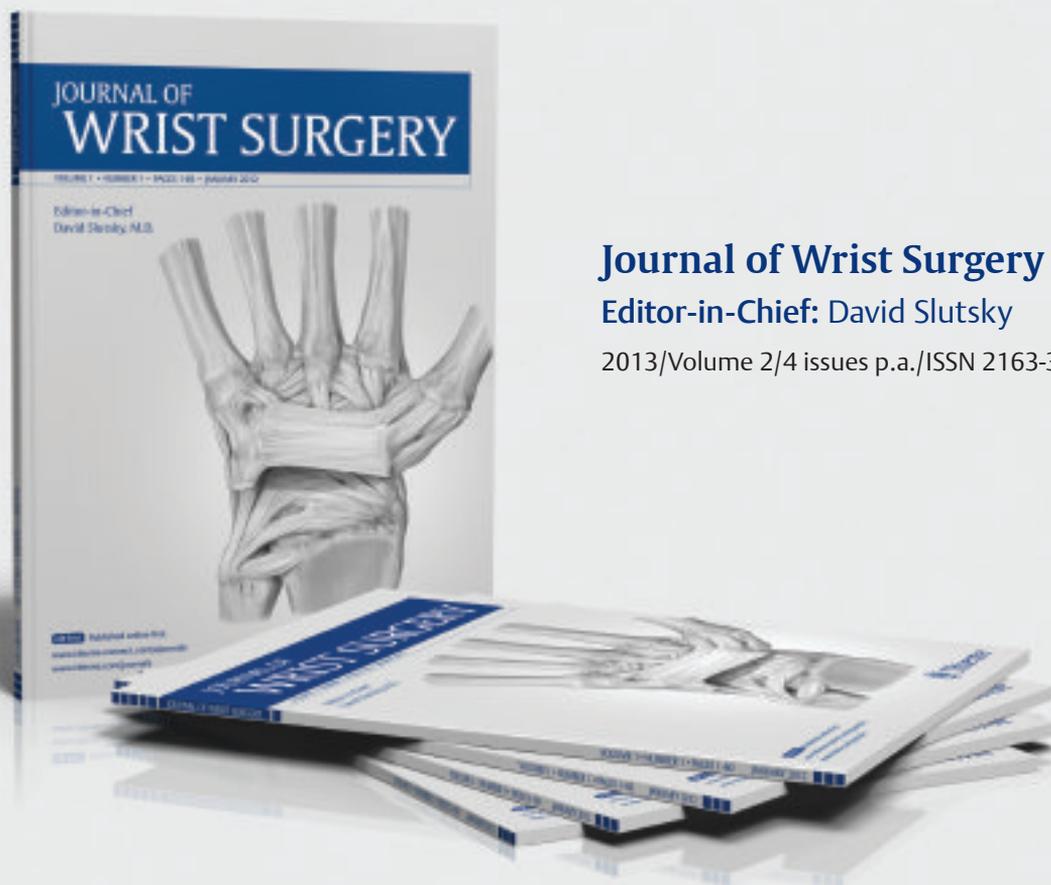
validated evaluation and outcomes tools. These assessment tools are specifically designed for upper limb involvement due to cerebral palsy, and provide the hand surgeons the means to evaluate extent of disease for specific individuals, as well as outcomes of treatment interventions.

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Therapeutic Exercise in Wrist Rehabilitation

Part 1

By Jennifer Blenkinsop

This article is the first of two dealing with rehabilitation of the wrist after injury. The first section deals with specific exercises using isometric and isotonic exercises. The next section, to be published in the August edition of the IFSSH ezine, will cover plyometric exercises, reactive muscle activation, mirror therapy and application of specific exercises in daily life.

Introduction

The goals of rehabilitation of the wrist vary significantly depending on the injury/ pathology, surgical procedure and patients' functional requirements. Generally for fractures without ligament injuries, the goal is full range of motion (ROM), and a strong, pain-free wrist capable of performing the normal functional tasks as previously performed by the patient. However, where ligament injuries or instabilities are present, a limited ROM with modified activity and functional expectations may be preferable or vital to achieving the goals of a

strong, stable, pain free wrist. Patient education, and often re-education, is pivotal in these situations.

The exercise principles that follow can be applied to most wrist injuries that do not include ligament injuries (or repairs) and/or instabilities, and where hypermobility is not a concern. However in cases of ligament injury (or repair) and/or instability and hypermobility an understanding of carpal kinematics and the specific pathology are essential to selecting the appropriate exercise as well as the timing of the exercises. Some of the exercises mentioned may need to be modified or omitted altogether for certain injuries. Unfortunately the range of possible wrist pathologies (along with the modified programmes) cannot be individually addressed, but some of the more common pathologies will be discussed.

Isometrics

Isometric exercises are very useful in the early stages of rehabilitation as the

amount of resistance and the ROM (if any) can be carefully controlled by the therapist (1). It also provides an early stage of proprioceptive input from muscle spindles and Golgi tendon organs (2), and later from mechanoreceptors in the carpal ligaments when the angle of the wrist joint is increased. The resistance may be applied manually by the therapist or the patient (as part of their home programme), and the position of the joint may be carefully selected. For wrist isometrics no gripping is necessary by the affected hand and therefore no axial loading need occur through the SLIL, making it a safe exercise for SLIL injuries and following surgical repair particularly in varying degrees of motion in the DTM plane. Because FCU, ERCL and APL appear to have a protective function towards the SLIL (3,4) isometric strengthening of these muscles in a protected, pain-free position may well be helpful following SLIL injury or repair. Research by Salva and Garcia-Elias (4,5,3) note

that isometric contraction of FCR and ECU is detrimental to the SLIL where the SLIL is disrupted or significantly injured, however isometric contraction of the FCR in the intact SLIL actually assists in providing joint stability.



In instances on mid-carpal instability isometric exercise of FCU and ECU, particularly together with exercising the hypothenar muscles provide increased dynamic stability to the ulna wrist, according to Lichtman (6), while FCU and the hypothenars may be important dynamic stabilisers in cases of lunotriquetral instability (as noted by Garcia-Elias (7)).



Isometrics may initially be performed with vision, and then without, and also as part of a mirror therapy programme. Research by Kotlyn et al (8) showed that submaximal (~20-50% of maximum) isometric exercise resulted in both ipsilateral and contralateral hypoalgesic responses. This may even add to the 'mirror neurone effect' of pain reduction, proprioceptive re-education and normalising cortical representation when used in conjunction with the mirror box.

Another method of utilising isometrics is using a small- to medium-sized ball. The patient is seated with the wrist in neutral, and the hand lightly

gripping the ball (which is resting on a table) with a very wide grip. The therapist then attempts to rotate the ball in different directions while the patient isometrically resists. Again the therapist can control the positioning of the wrist and the ROM according to the type of injury. This is initially done slowly with vision (and auditory cues if needed), and then graded to increase the speed to quicken the muscle reaction time to changing demands (early stages of what has now been called reactive muscle activation). Another method of grading the exercise is to begin with the wrist in neutral, and then to slowly progress to greater degrees of wrist extension depending on the injury. It may also be done with vision and then without.



“Isometric exercises are very useful in the early stages of rehabilitation as the amount of resistance and the ROM (if any) can be carefully controlled by the therapist”

Isotonic exercises

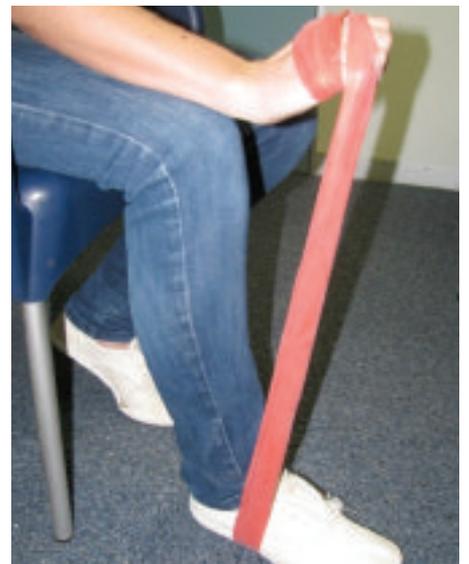
These exercises carried out against a constant or variable load as the muscle lengthens or shortens through an available range of motion. They may be concentric, eccentric or both, and

focus mainly on improving dynamic strength, muscle endurance and power (1). Most daily living activities, including sports and creative activities include both concentric and eccentric muscle contractions and these may therefore need to be included as part of the complete approach to wrist rehabilitation.

Eccentric exercises require a relatively higher muscle force (than concentric exercises), but with a lower energy requirement. They are also important in preparation for plyometric exercises which are used in the late stage of rehabilitation of wrist injuries in those patients with higher functional requirements of their wrists and upper quadrants. Eccentric exercise have often been associated with causing injury, however their careful and judicious use can significantly increase strength, power and the “spring characteristic” of muscle required for many daily and athletic activities (9). This may not only enhance performance and motor control, but may also assist in prevention of injuries caused by sudden unanticipated loading. The protective mechanism may well be a combination of enhanced muscle function as well as proprioceptive input from muscle spindles, Golgi

tendon organs and mechanoreceptors in joints stimulated by motion and joint position. According to Leger and Milner (10) following sub-maximal eccentric wrist extension exercises (to exhaustion of the wrist extensors), co-activation of the wrist flexors was noted when attempting to extend the wrist thereafter. This may be related to antagonists attempt to provide protection and global stability to the wrist when the risk of injury is increased. This may indicate the additional proprioceptive benefit of eccentric exercises.

Wrist curls, using free weights or products like resistive elastic/ rubbers bands can produce both concentric and eccentric isotonic contractions in the same exercise, and are commonly used in the clinic as well as part of a home programme post-distal radius fracture and those wrist injuries that do not include ligament injuries or instabilities. They may be done in pure ranges of motion ie. wrist flexion, extension, RD and UD or in more anatomical planes of motion (eg. DTM) depending on the pathology. Assisting with the unaffected hand can limit the type to either concentric or eccentric contraction only if needed.

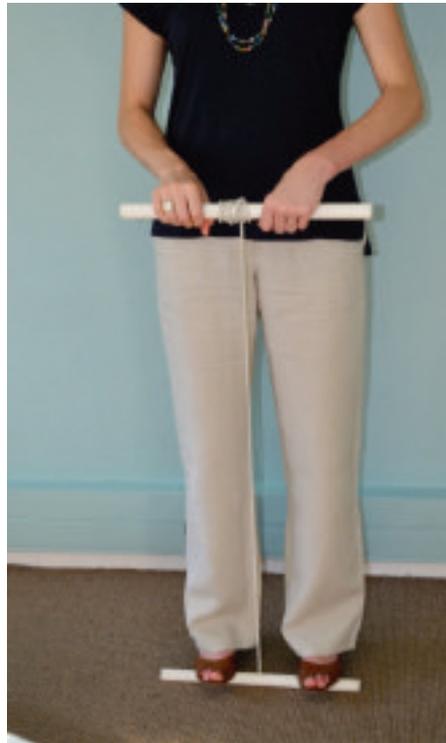


Rubber bars eg. Theraband Exercise Bar may be used for wrist flexion/extension as well as supination and pronation. The additional benefit is that the exercise is bilateral and reciprocal in the case of flexion/extension and symmetrical in the case of supination and pronation. Asymmetrical bilateral co-ordination is more challenging in terms of motor control than is symmetrical bilateral co-ordination (2). Therefore the use of this exercise form can be graded from symmetrical to asymmetrical, if needed, as motor control improves. The ‘Physiociser’ consists of two rods with a long piece of strong elastic in between. The patient stands on the one rod, and with an asymmetrical, reciprocal motion winds up the elastic.

About the author

Jennifer Blenkinsop runs a Private Hand Therapy Practice in Johannesburg, South Africa. Her qualifications include BSc (OT), Certified Hand Therapist (CHT), Complex Lymphoedema Therapist (Casely-Smith), Guided Imagery and Music Fellow (FAMI- Bonny Method). Please direct all comments and enquiries to Jennifer at jblenkinsop@tiscali.co.za

Initially there is no resistance, which may be useful for ROM. However, as the patient continues the action the resistance becomes greater and greater, requiring isometric hold and concentric contractions as the resistance increases. If the bar is slowly released there is an isometric hold and eccentric contraction. The reciprocal motion is important in neuromuscular control and proprioception.



Exercises may be graded from simple exercises involving the wrist and hand only, to those involving the upper quadrant in functional movement patterns or patterns specifically related to the functional demands of the patient. An example of this would be slowly imitating portions of a tennis stroke using a Theraband or a weighted pulley system, or imitating the motions required by work tasks with resistance provided by free weights or resisted rubber bands. These are performed slow, controlled manner.

Again these exercises may be performed using a mirror box to improve sensorimotor control and work towards normalizing cortical representation and pain modulation. Motor control may also be improved by activation of mirror neurons.

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Pioneers in Hand Surgery

Joseph H. Boyes

1905-1995

Joseph H. Boyes was born in Hebron, Nebraska USA on the 31st March 1905. He studied medicine at Stanford University, graduating cum laude MD in 1930. After an assistantship in Hand Surgery with Sterling Bunnell from 1934 to 1938, he set up practice in Los Angeles. Between 1942 and 1946, he did Army service in China and Burma. After the war he resumed his practice and offered a Hand Surgery Fellowship, which produced 125 hand surgeons.

Joseph Boyes was a founding member of the American Society for Surgery of the Hand, and served as its first Secretary. In 1954 he became the President of the ASSH. After the death of Bunnell, Boyes edited Bunnell's 'Surgery of the Hand'. He was also the Editor-in-Chief of the American Journal of Hand Surgery from 1976 to 1982. It was Boyes who encouraged speakers to follow his own advice when presenting a lecture, namely to "be bright, be brief and be seated"!

In 1977 Joseph Boyes was awarded an Honorary Fellow by the Edinburgh College of Surgeons. Boyes was known as a master surgeon, being precise, accurate and rapid because of his economy and unnecessary movements while performing an operation. It was because of his surgical skills, his superior command of the English language, his clear and to the point lecturers, his many contributions to hand surgery and as role model that he was honored as 'Pioneer of Hand Surgery' by the IFSSH at its third Congress in 1986 in Tokyo, Japan.



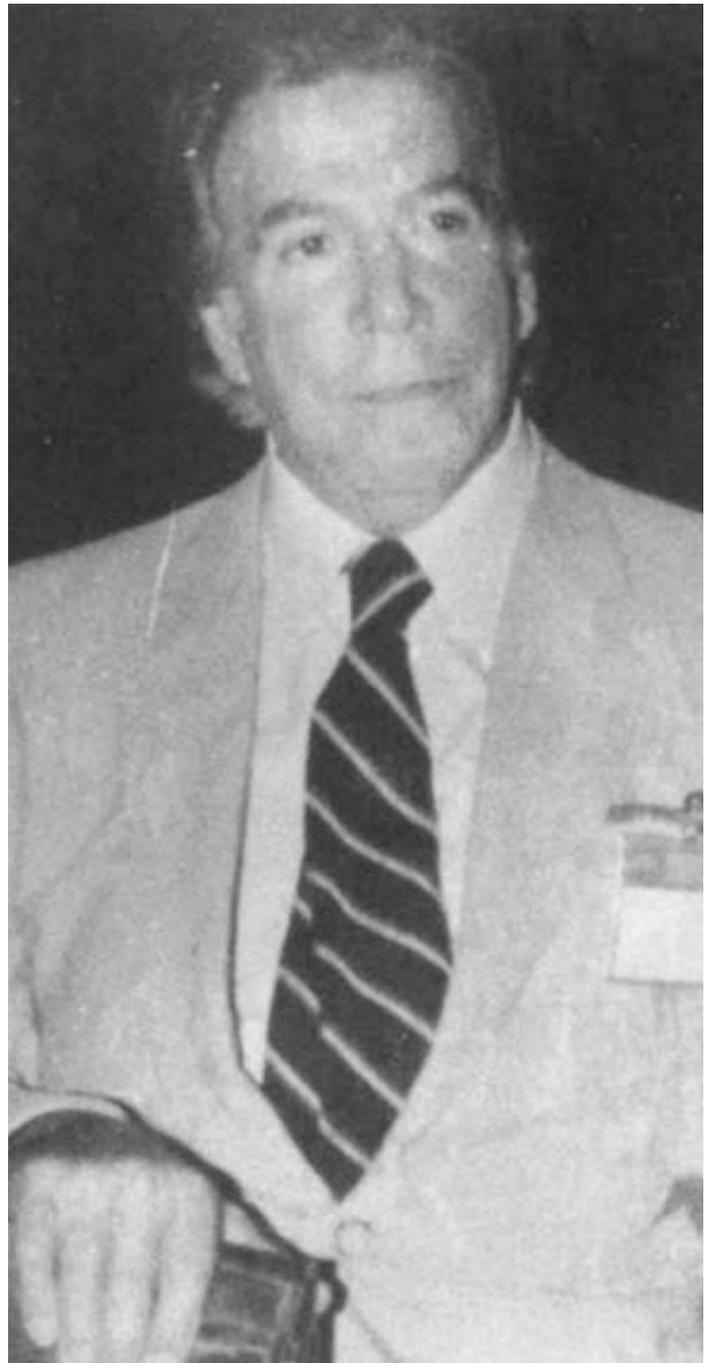
Mario Gonzalez-Ulloa

1913-1995

Mario Gonzalez-Ulloa was born in Chihuahua, Mexico. In 1929 he started his medical training in Mexico City. He then trained for three years in the United States. From 1939 until 1942 he worked as a plastic surgeon in the Cancerology Service of the General Hospital in Mexico City. During World War II, he practised reconstructive surgery in military hospitals in Great Britain. In 1948 he founded and was the President of the Mexican Society of Plastic Surgery. In 1954 he became a member of the American College of Surgeons and in the same year he was President of the Latin American Meeting of Plastic Surgery. He was an associate member of the Royal College of Medicine, as well as member of the American Cleft Palate Association and the American Society of Aesthetic Plastic Surgery. Gonzalez-Ulloa was instrumental in the formation of the International Society of Aesthetic Surgery, was elected President in 1973 and played a key role in organising the 1975 international meeting in Mexico City. During his career he authored over 50 publications on reconstructive and aesthetic surgery. He was a keen proponent of humanistic and philosophical issues and has written a number of papers on these topics. He published a book entitled: "Daring to Live", in which he gives his reflections on loving, laughing and getting old.

Mario Gonzalez-Ulloa was indeed a man of many talents, a well-loved lecturer and teacher and incorporated his medical career into the larger picture of life. He was regarded by his students as a father figure, a philosopher and a spiritual guide. It was for all these contributions that the Mexican Society for Surgery of the Hand proposed Mario Gonzalez-Ulloa to be honored as 'Pioneer of Hand Surgery' by the IFSSH at its third Congress in Tokyo, Japan in 1986.

He was married to Ruth and together they had five children. Mario Gonzalez-Ulloa died on 3 March 1995.



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- Vascularized bone grafts for the treatment of carpal bone pathology
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- The effect of time after shear injury on the subsynovial connective tissue and median nerve within the rabbit carpal tunnel
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- Clostridium perfringens infection following carpal tunnel release
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- Primary repair of zone I flexor tendon injuries
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- Macrodactyly in the Setting of a Plexiform Schwannoma in Neurofibromatosis Type 2: Case Report
- Extensile Surgical Exposures of the Radius: A Comparative Anatomic Study
- A Comparison of the Long-Term Outcome of Partial Articular (AO Type B) and Complete Articular (AO Type C) Distal Radius Fractures
- Essential Hand Surgery Procedures for Mastery by Graduating Orthopedic Surgery Residents: A Survey of Program Directors
- The Overutilization of Resources in Patients With Acute Upper Extremity Trauma and Infection

Upcoming events

Advanced Derby Hand Course

23-24 May 2012

Derby, United Kingdom

www.pulvertafthandcentre.org.uk

The Pulvertaft Hand Centre, Derby, UK is hosting this comprehensive two-day conference for Hand Surgeons, including: Case based discussions, tips and hints on technique from the experts, current concepts in hand surgery, controversial management issues. Leading national and international Faculty will debate topics including: Dupuytren's Contracture, the Wrist, trauma, flexor tendons, peripheral nerves, joint replacement, CMCJ thumb.

FESSH Congress 2013

29 May – 1 June 2013

Antalya, Turkey

www.fessh2013.com

The 18th FESSH Congress will be held at the capital city of the Turkish Riviera, Antalya between 29 May and 1 June 2013. Antalya is located on the southwestern coast of Turkey. The region is famous for its historical heritage, blue sea, warm weather and is accessible with direct flight from European cities. Detailed information about the congress is available on www.fessh2013.com.



68th Annual Meeting of the American Society for Surgery of the Hand

October 3-5, 2013

Moscone West Convention Center, San Francisco, CA, USA

www.ASSHAnnualMeeting.org

Annual Meeting program chairs Michael Hausman, MD and Fraser Leversedge, MD look forward to a robust program at the 68th Annual Meeting of the ASSH.

3rd Annual RAMSES Multispecialty Robotic Microsurgery Symposium

8-9 November 2013

Strasbourg, France

www.roboticmicrosurgeons.org

The only multi-specialty microsurgical gathering of its kind—with microsurgeons from varying fields, including: hand, plastics, reconstructive, ENT, urology, gynecology, ophthalmology, vascular, orthopaedics, pediatrics and peripheral nerve.

Arthroscopy and arthroplasty of the wrist

22-23 November 2013

Arezzo, Italy

www.sicm.it/norme_editorialien.html

The course is designed for specialists in hand surgery, orthopaedics and plastic surgery who want to improve their technical skills in the diagnosis and treatment of wrist disease. Experts will take lectures and presentations followed by arthroscopic and open surgical techniques on anatomical specimens. Sessions will consider clinical diagnostics for each form of instability or other pathologies of the wrist. Open and arthroscopic techniques will be presented in details with their specific indications. Each participant will bring clinical cases to discuss with experts and will have at least one anatomical specimen.

LEARNING OPPORTUNITY
only 4 places available

Synthes Fellowship in Hand and Reconstructive Microsurgery

Ganga Hospital, Coimbatore, India
6-8 weeks

This fellowship is an educational initiative of the Department of Plastic and Hand and Reconstructive

Microsurgery department of Ganga Hospital, Coimbatore, India and Synthes to promote Hand and Reconstructive Microsurgery. Four fellowships are available every year. This enables the selected fellows to spend 6 to 8 weeks in the department and take part in all the academic and clinical activities of the unit.

Ganga Hospital, situated in South India is a 450 bed hospital, exclusively catering to the two specialties of Plastic and Hand Surgery and Orthopaedics. The department has a busy trauma reconstructive surgery load in addition to undertaking all aspects of Hand Surgery and the lower limb reconstruction work provides ample opportunities for microsurgery. The department has a good microsurgery training laboratory, which regularly runs week long microsurgery courses.

The fellowship provides free comfortable accommodation for the period of stay in the Hospital apartment and an allowance of Rs 35000 to Rs 40000 (depending upon the exchange rates) for incidental expenses. The fellowship also includes the fees (US \$ 750) to undertake the one week long full time Microsurgery course in the Ganga Microsurgery Laboratory.

We would like to choose candidates with a professed interest in Hand and Reconstructive Microsurgery. While experience in the field is preferred, it is not essential. The sponsors of the fellowship are keen that candidates should be working in an environment where they will be able to utilise the experience gained for better patient care. Both Plastic Surgery and Orthopaedic trained Hand Surgeons are eligible to apply.

How to Apply?

Interested candidates are requested to send in their CV with two referees, a photograph with a note about how the fellowship will be useful to them. Please send it to DR S Raja Sabapathy, Chairman, Department of Plastic

Surgery, Hand and Reconstructive Microsurgery, Ganga Hospital, Coimbatore, India at rajahand@vsnl.com. Applications are invited for 2014 and the applicants are requested to also specify the preferred period of stay.

“Anyone who stops learning is old, whether at twenty or eighty. Anyone who keeps learning stays young.” — Henry Ford

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This year we have:

- A welcome reception dedicated to honoring our international attendees.
- 52 Instructional Courses.
- 12 pre- and post-courses, including two hands-on skills courses.
- A bustling exhibit hall and various industry forums highlighting the latest products.
- Inspiring and thought-provoking keynote speakers.

68TH ANNUAL MEETING OF THE ASSH

**EDUCATION
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OCTOBER 3-5, 2013



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