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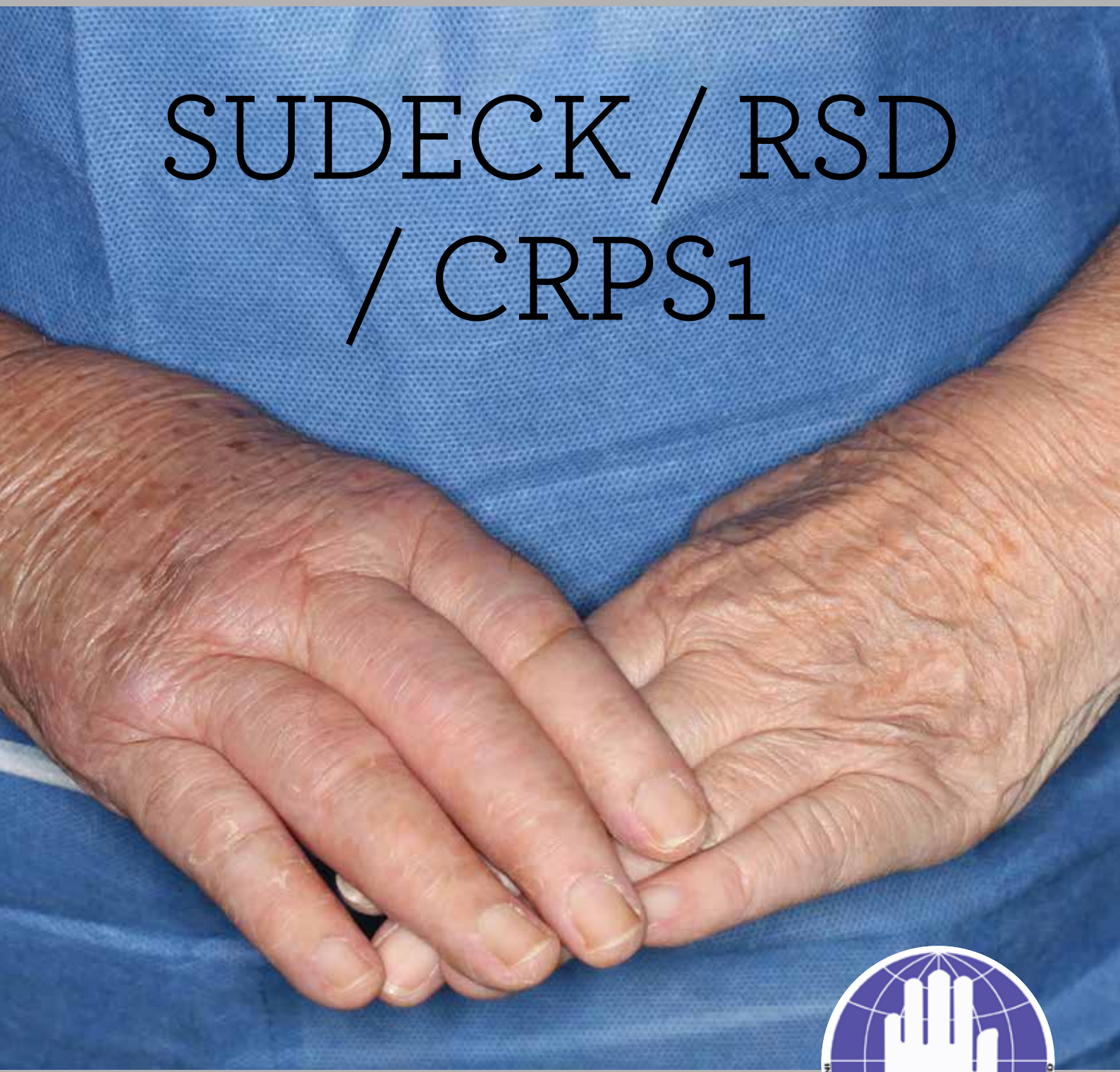
ezine ifssh

CONNECTING OUR GLOBAL HAND SURGERY FAMILY

SPECIAL FEATURES

· REFLEX SYMPATHETIC DYSTROPHY (RSD)/CRPS/SUDECK DOES NOT EXIST

· OUTCOME MEASUREMENT IN HAND SURGERY



SUDECK / RSD / CRPS1

UPCOMING EVENTS | RESEARCH ROUND-UP |

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EDITORIAL

IFSSH/IFSHT Congress, Berlin 2019

The 14th triennial IFSSH Congress has been a huge success. Not only "bigger and better" in size, attendance and organization, but also academically the choice was outstanding.
This again emphasizes the importance of the IFSSH function: to create a platform for Hand Surgeons and Hand Therapists from all over the world to share their experience, ideas and expertise.
And to interact: building bridges
Well done Berlin!

Points to Ponder

This August Ezine issue features two thought provoking presentations.
Both challenge conventual thinking.
Both examine long held "truths".
Both demand a rethink of concepts which we have propagated from one generation to the next.
Both ask for a paradigm shift in our clinical practice.
There may be (and probably are) more long held diagnoses,concepts, didactic dogmas, surgical techniques, diagnostic methods, customs, and mannerisms which need "updating".
The challenge is on!

With sincere regards,
Ulrich

Prof. Ulrich Mennen
Editor: IFSSH Ezine
Past President: IFSSH

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CONNECTING OUR GLOBAL HAND SURGERY FAMILY

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President: Acceptance Speech

My dear colleagues:
I wish to thank you, members of the Member Societies of this Federation, for having placed your trust and confidence in me. Being asked to serve as the 19th President of the International Federation of Societies for Surgery of the Hand is an honour, and an undeserved privilege which I will treasure all my life.

As you probably know, I am a wrist surgeon, and a basic science enthusiast, fascinated by the anatomy and mechanics of the wrist. Maybe because of this, I know that even the most simple structure becomes complex when you look at it carefully enough. Yet, we should not regard complexity as a threat, but as an opportunity to see further, a challenge to overcome. Complexity is only a problem if one is afraid of facing it. This is how I think we should work in this Federation. Let us not see "the different" as a threat, but as another indispensable face of the polyhedron,we live in. In the IFSSH there is no place for qualifying adjectives that set borders, but only for those that erase them.

Aside from an anti-supremacist, I am also a compulsory optimist, a positive thinking type of person who is not afraid of facing problems as a part of life. I like seeing the glass half full rather than half empty. I believe in finding solutions where others only see problems, and I wish I could contaminate you all with this attitude. To me that is the only way to do things. This does not mean that I disregard how significant this commitment is. I know it will be hard, but I am ready to build upon the successes of the past and do whatever I can to fulfill our mission, which is no other than to promote hand surgery throughout the world, to protect your interests worldwide, and to look after the wider community of hand patients.

Let's not finish this without expressing our gratitude to the outgoing Immediate Past President Michael Tonkin. Always kind, always humble, he provided the IFSSH with direction and leadership over the last few years. He handled many difficult issues effectively. I learned from him what "keep calm" means, despite my pronunciation was never being right. But above all, he was effective at keeping non-essential issues out of the boardroom. These traits I intend to continue during my term.

Thank you, Michael, and thank you all so much again.

Best wishes!

Marc
Kind regards,

Marc Garcia-Elias
President: IFSSH.

Welcome from the incoming Secretary-General

It is a great honour for me to have the opportunity to serve the IFSSH as Secretary-General. During the previous three years as Secretary-General Elect, I tried to learn the heritages and legacies of the Federation as much as possible.

The IFSSH now has 60 Member Societies from all over the world whose cultures, languages, and ways of thinking differ from each other.Although I do not understand all the differences of the various countries, I found that we can find agreement amongst ourselves through harmony and teamwork.

The Bylaws of the Federation state that its mission is to coordinate the activities of all the Societies for Surgery of the Hand throughout the world, and in this way to promote knowledge of surgery of the hand.

Under the guidance of Marc Garcia-Elias, our new President, and with the help of the Executive Committee members and the Member Societies, I will do my best to coordinate the activities of the Member Societies and to increase and spread this knowledge, especially to the disadvantaged members and young hand surgeons.

Goo Hyun Baek
Secretary-General, IFSSH
Email: secretary@ifssh.info

Future Meetings
A detailed list of national and regional hand surgery meetings is available on the IFSSH website. The triennial IFSSH Congresses are as follows:

XVth IFSSH – XIIth IFSHT Congress London, United Kingdrom
27th June - 1st July, 2022

XVIth IFSSH – XIIIth IFSHT Congress Washington D.C., USA
29th March - 3rd April, 2025

MESSAGE FROM OUTGOING SECRETARY-GENERAL: DANIEL NAGLE

The 14th Triennial Congress of the International Federation of Societies for Surgery of the Hand and the 11th Triennial Congress of the International Federation of Societies for Hand Therapy were held in the Berlin CityCube from June 17 through June 21. This was the first Congress to include many activities of the Federation of European Societies for Surgery of the Hand (FESSH). The organizing committee chaired by Professor Jörg van Schoonhoven, Professor Max Haerle, Professor Andreas Eisenschenk, Natascha Weihs & Beate Jung orchestrated an extraordinary Congress. Over 4000 physicians and therapists participated in this meeting representing 92 countries. The Congress theme was "Building Bridges Hand in Hand" and given the massive international attendance it is clear the Congress did indeed accomplish that goal.

The meeting featured a pre-Congress Monday education day which featured many industry sponsored courses and lectures. The Congress officially opened Monday afternoon with the Opening Ceremony that featured the recognition of newly nominated Pioneers of Hand Surgery. Thirty-seven Pioneers from 19 societies were honored. These Pioneers along with their families travelled from all over the world to participate in this ceremony that was indeed monumental and inspiring. The Opening Ceremony was followed by a cocktail party with an entertaining performance from "The Carpal Boss and Loose Bodies" band, featuring many hand surgeons and therapists from around the world.

The scientific program was impressive. There was an overwhelming response to the Call for Abstracts, with 1800 submissions assessed by 242 reviewers. The Congress Organizing Committee then appointed 45 German colleagues to lead 27 subgroups and work with 27 international hand experts to build the scientific programme. The final program included 357 invited lectures and 1123 free papers overseen by 347 chairpersons.

The IFSSH Delegates met on Wednesday, June 19, 2019. The first order of business was to welcome a new member to the IFSSH family, the Ecuadorian Society for Surgery of the Hand. The Ecuadorian society is the 60th society to join the IFSSH!

The next order of business was the election of the new Executive Committee (ExCo):

Immediate Past President:	Dr. Zsolt Szabo of Hungary
President:	Dr. Marc Garcia Elias of Spain
President Elect:	Dr. Daniel Nagle of the United States
Secretary-General:	Dr. Goo Hyun Baek of South Korea
Secretary-General Elect:	Dr. Raja Sabapathy of India
Historian:	Dr. David Warwick of England
Member at Large:	Dr. Jin Bo Tang of Association of Chinese-speaking Hand Surgeons United

The ExCo, during the coming months, will be working with the Delegates on much needed bylaws changes as well as structural changes to increase Society participation in the ExCo.

The Delegates were then charged with the selection of the 2025 IFSSH triennial meeting site. Dr. Scott Levin, the current President of the ASSH, presented the well-prepared bid by The American Society for Surgery of the Hand and the American Association of Hand Surgery to host the 2025 IFSSH Triennial Congress in Washington DC. Dr. Marcello Rosa de Rezende, President of the Brazilian Society for Surgery of the Hand, provided the Delegates with an excellent presentation promoting Rio de Janeiro for the 2025 IFSSH Congress. Finally, Dr. Luis Naquira, President of the Colombian Association of Hand Surgery, gave a rousing presentation urging the Delegates to support the Colombian bid to take the 2025 IFSSH Congress to Cartagena de Indias. In spite of excellent presentations by Dr. Rezende and Dr. Naquira, the American bid prevailed. The 2025 15th Triennial IFSSH Congress will be held in Washington DC, USA from March 29 to April 3. The IFSSH is very indebted to the American, Brazilian and Colombian Societies for their dedication to the creation of extraordinary bids and superb presentations.

This year's invited Swanson Lecturer was Dr. Steven Hovius who provided an insightful and thought-provoking discussion of the challenges facing hand surgeons around the world as they try to provide the best care to their patients.The Presidential Guest Lecture was delivered by Professor Dr. Klaus Leisinger, raising the interest of participants with his thoughts on "Critical issues for a world we want: What do we know? What shall we do? What may we hope?"

Of course, every IFSSH Congress provides opportunities for social interaction between the members of our member societies. The German society organized a "Berlin Night" at a renovated cold storage facility (The Kühlhaus) dating back to the early 20th century. High powered music filled the air while attendees danced and enjoyed iconic German food and drink. The Gala dinner was held on Thursday night at the Ritz-Carlton and featured great food and drink as well as an outstanding band that kept hand surgeons and therapists dancing into the wee hours of the morning.

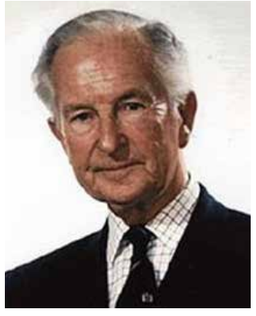
Once again, many thanks to the German Society for Hand Surgery, German Society for Hand Therapy, Federation of European Societies for Surgery of the Hand and the International Federation of Societies for Hand Therapy for putting on a truly extraordinary Congress, Bravo!

Best wishes to all.
Dan

Daniel Nagle
President Elect, IFSSH

STEWART H. HARRISON

LDS, RCS (Edinburgh), FRCS (England) United Kingdom (1912 - 2011)



Stewart H. Harrison was born on 15 July 1912 in Highgate, London, UK. Both parents died when he was still a pre-schooler. He was brought up by his maternal grandparents in Dunblane, Scotland, and attended Stanley House School in Bridge of Allan.

In 1934 he qualified in Dentistry and in 1935 in Medicine at the Edinburgh University, Scotland. He obtained his FRCS from Edinburgh in 1938.

During the Second World War, he served as Major in the Royal Army Medical Corps, stationed in Nigeria and later in north-west Europe. Following the war, he worked at the Birmingham Accident Hospital, training under Sir Harold Gillies. In 1958 he worked with Rainsford Mowlem at the Mount Vernon Hospital where he developed a number of operations, amongst others the technique of delayed primary flexor tendon grafts for flexor tendon injuries. His plastic and reconstructive surgery background saw him promoting the novel concept of primary flap cover of open lower leg injuries by cross leg flaps. This new technique drastically reduced the infection rate. These cross leg flaps have now been replaced by micro-vascular free flaps, but the principle stays the same.

Another of his pioneering contributions was pollicisation for the Thalidomide cases, tendon transfers as a prophylactic procedure to prevent the deforming cycle of the rheumatoid wrist, and early PIP joint fusion with his newly developed polypropylene intramedullary pegs. In 1979 Harrison was appointed the Hunterian Professor for his contribution to the treatment of the rheumatoid hand.
He also wrote articles on the surgical management of burn injuries, cranio-facial reconstruction and chronic infection of the axilla.

In 1956 Stewart Harrison, Adrian Flatt, Robert Robbins, Douglas Reid and Graham Stack started the Second Hand Club, which unlike the First Hand Club, had an open membership! The two Hand Clubs joined together in 1968 to become the British Society for Surgery of the Hand. He served as President in 1972. In 1976 he was elected President of the British Association of Plastic Surgeons.

His last 5 years of retirement was spent in Spain where he died on 12 May 2011 at the age of 98 years.
Stewart Harrison was married to Phyllis Eustace in 1942, and they have one son.

At The Eighth Congress of the International Federation of Societies for Surgery of the Hand in Istanbul, Turkey, 10 June 2001, Stewart H. Harrison was honoured as “Pioneer of Hand Surgery”.

HANNO MILLESI MD

Austria (1927 - 2017)

Hanno Millesi was born on 24 March 1927, the son of a general practioner in Villach, Carinthia, Austria. In 1951, he received his medical degree from the University of Innsbruck Medical School. He then trained in pathology and internal medicine at the Wilhelminen Hospital in Vienna, and in general surgery and plastic surgery at the 1st Surgical Clinic, University of Vienna Medical School. He studied with Dr. Alan Ragnell at the Stockholm Surgical Hospital, Sweden. In 1967 he obtained his postdoctoral qualification based on extensive research on the pathogeneses of Dupuytren’s contracture.

Millesi was appointed Head of the Section of Plastic Surgery, 1st Surgical Clinic, University of Vienna Medical School and Associate Professor of Plastic Surgery in 1972. He was Professor of Plastic Surgery at the Vienna University Medical School from 1982 until 1995, when he became Professor Emeritus. In 1974 he founded the first 24-hour replantation service in Europe with colleagues from both Surgical University Clinics in Vienna. He was appointed Director of the Ludwig-Boltzmann Institute for Experimental Plastic Surgery, Vienna (1975), and Head of the new Plastic and Reconstructive Surgery Clinic of the University of Vienna (1993). In January 1996, he became Medical Director of the Vienna Private Hospital.

He authored or edited 20 textbooks and over 320 scientific publications on his areas of study, including the pathogenesis of Dupuytren’s contracture; mechanical properties of palmar aponeurosis, tendon, skin, and scar tissue; biomechanical properties of elastase; healing of nerves; gliding apparatus of peripheral nerves; microsurgery of peripheral nerves; interfasicular grafting of median and ulnar nerves, and nerve grafting of the brachial plexus.

He was a member of 21 scientific societies including the Austrian Society for Surgery of the Hand, and the American, British, French, Italian, Spanish, Venezuelan, and Turkish Hand Societies, and the International College of Surgeons. He was Founding Member and President of the Austrian Society of Plastic Surgery (1971-75), International Society of Reconstructive Microsurgery (1972-73), German Speaking Study Group on Peripheral Nerves and Vessels (1978-82), and the Austrian Society for Surgery of the Hand (1989-96). He was President of the Sunderland Society (1985-86) and the International College of Surgeons-Austrian Section (1985-1998), and member of the Executive Council of the International Confederation for Plastic, Reconstructive and Aesthetic Surgery (1987-95).

Prof. Millesi has received numerous honours and awards, amongst others: Hoechst (1967), Eiselsberg (1972) and German Society of Surgery Jubilee (1974) prizes. Gold Medals from the Italian Club of Microsurgery (1980) and the cities of Vienna (1987) and Milan (1988), Doctor Honoris Causa University of Breslau, Poland (1980), Commandant of the Italian Republic (1982), Austrian Golden Award for Science and Research (1995). He gave the Moberg (1973), Kazanjian (1975) and ASSH Founder (1987) Lectures.

At the age of 90 years, Hanno Millesi passed away on 28 April 2017 in Viena, Austria.

In May 1998, Prof. Dr. Hanno Millesi was honoured as ”Pioneer of Hand Surgery” by the IFSSH at its Seventh International Congress in Vancouver, B.C., Canada

Reports from IFSSH affiliated Organisations

ASIAN-PACIFIC FEDERATION OF SOCIETIES FOR SURGERY OF THE HAND (APFSSH) 2019 REPORT

19th June 2019, Goo Hyun Baek

Current Member Societies (13)
Australian Hand Surgery Society
Bangladesh Society for Surgery of the Hand
Hong Kong Society for Surgery of the Hand
Indian Society for Surgery of the Hand
Indonesian Society for Surgery of the Hand
Japanese Society for Surgery of the Hand
Korean Society for Surgery of the Hand
Malaysian Society for Surgery of the Hand
New Zealand Society for Surgery of the Hand
Association of Hand Surgeons for the Philippines
Singapore Society for Hand Surgery
Taiwan Society for Surgery of the Hand
Thai Society for Surgery of the Hand

Observer Societies (5)
China Society for Surgery of the Hand
Myanmar Society for Surgery of the Hand
Pakistan Society for Surgery of the Hand
Vietnam Society for Surgery of the Hand
Sri Lanka Society for Surgery of the Hand

APFSSH Executive Committee
President: Goo Hyun Baek (Korea)
President-Elect: Raja Sabapathy (India)
General Secretary: Tony Berger (Australia)
General Secretary-Elect: Fuminori Kanaya (Japan)
Immediate Past President: Yuan-Kun Tu (Taiwan)

Official Journal of APFSSH
'The Journal of Hand Surgery Asian-Pacific Volume' since 1996
Published 4 issues (Mar, June, Sep, Dec)

APFSSH Congresses
11th APFSSH Meeting: Cebu City, Philippines (7th -10thOctober, 2017)
12th APFSSH Meeting, Melbourne, Australia (9th -11th March,2020)
13th APFSSH Meeting, Singapore (May, 2023)

This past year has seen many developments in the activities of the APFSSH. Many of the original aims of the first Charter of the APFSSH being to promote Hand Surgery and Education in the Region and to support a Travelling Fellowship have been somewhat hampered by a lack of funds and difficulties in coordinating activities throughout the region under the umbrella of the APFSSH. All the member societies are very active in their own countries and have frequent combined scientific meetings. The Federation has some funds but these are being held by member societies from donations and from the running of our scientific meetings.
In order to increase the activity of the Federation the executive has over the past 2 years been working towards establishing an office and a bank account where funds can be collected and then used to achieve the aims of the Federation. With so many differing countries and laws in the region this proved to be a little difficult but with the work of our Singaporean colleagues we are on the threshold of opening an account and having an administrative base in Singapore. In order to satisfy the financial requirements of Singapore it has also been necessary to establish a proper Constitution. This has been a monumental task with useful contributions from many members of our Federation. The Constitution was voted on and adopted by the executive and member delegates at a Council meeting in Taiwan last month. With a few details to complete over the next few months the Federation will soon be able to achieve its aims in the region.

The Journal of Hand Surgery Asian Pacific Volume, is the official journal of the APFSSH which is published 4 times a year. 181 articles are submitted in 2018, and acceptance rate was 36%.

The Federation website is also undergoing a redevelopment and with the increased activity of the Federation we hope to encourage more contributions to the website with meeting announcements and other educational activities.

With the Constitutional work completed the attention of the Federation is now directed towards the next APFSSH meeting to be held in Melbourne Australia in March 2020. This is co-convened by the Australian and New Zealand Hand Surgery Societies and the Asian Pacific Wrist Association. It is again held in conjunction with the APFSHT with many combined sessions. We are also trying to support registrations from hand surgery societies from developing nations in our region by offering reduced registration rates and raising funds from other registrations to further support attendees from these member societies.

Whilst Melbourne may be far to travel for some Members, I would like to encourage as many of you as possible to attend. I am sure the trip will be worthwhile.

HAND AND WRIST BIOMECHANICS INTERNATIONAL (HWBI)

www.hwbi.org

The hand and wrist represent one of the most challenging structures in the study of biomechanics, as well as in the evaluation of many biomechanical principles. Hand and wrist biomechanics has been somewhat under developed in comparison to mainstream biomechanics research over the past century. While numerous biomechanical studies have been initiated by surgeons and engineers, collaborative efforts among scientists and clinicians are required in order for continuing progression in research and further improvement of treatment modalities and outcomes.

For over 25 years, the International Symposia on Hand and Wrist Biomechanics have provided the opportunity for global scientific exchange and mutual encouragement among basic science and clinical investigators. In 2012, the International Advisory Board decided to form Hand and Wrist Biomechanics International (HWBI) to further enhance the development of hand and wrist biomechanics and its clinical applications. It is our hope that through the structured organization of HWBI, research activities related to hand and wrist biomechanics will be elevated and clinical translation will be improved.

HWBI is affiliated with International Federation of Societies for Surgery of the Hand (IFSSH) and the International Society of Biomechanics (ISB). With these affiliations, the HWBI benefits from IFSSH's and ISB's established excellence as premier international organizations and their vast umbrella networks in promoting basic science and clinical applications. In turn, the HWBI contributes its specialty knowledge to the broad fields of hand surgery and biomechanics. HWBI regularly organizes symposia in conjunction with IFSSH and ISB congresses.

IFSHT REPORT TO IFSSH EXECUTIVE COMMITTEE MEETING

17 JUNE 2019. Anne Wajon, President IFSHT
City Cube, Berlin

IFSHT PRESIDENT ACTIVITIES 2016-2019

- Hosted IFSHT EXCO interim meeting in Hong Kong, 2017 to prepare goals for current term
- Approved and appointed an administrative assistant
- Finalised adjustment of IFSHT membership fees to be more equitable and sustainable, effective
- January 2020
- Deleted the Commercial membership category (to be voted on at Council meeting)
- Rewrote the IFSHT contract template for future congresses, and updated signed agreements for
- Berlin 2019 and London 2022
- Represented IFSHT at Eurohand 2017, ASHT 2017 and 2018, APFSHT 2017, EFSHT 2018
- Attended site visit in Berlin, 17-19 June 2018, in preparation for 2019 Congress
- Continue to update website content, including offering online applications for membership, awards and grants, as well as informing members of online resources and educational opportunities.

IFSHT TRIENNIAL MEETINGS

11th IFSHT Triennial Congress / 14th IFSSH Triennial Congress, 2019 Berlin, Germany

- 30-year IFSHT anniversary – goniometers purchased as celebratory keep-sake
- Inaugural presentation of Lifetime Achievement award
- Worked with our international Co-chairs of the Scientific Program to ensure high quality workshops and papers at Congress

12th IFSHT Triennial Congress / 15th IFSSH Triennial Congress, 2022 London, UK

- Website address updated to ifssh-ifsht2022.com.
- Nicola Goldsmith (President-elect) working with BAHT and IFSSH after completion of Berlin 2019.

13th IFSHT Triennial Congress / 16th IFSSH Triennial Congress, 2025

- Received bids: Delegates will be voting on combined ASSH/AAHS/ASHT in Washington
- DC, ASOCIMANO/ASCOTEMA in Cartagena, Columbia and from SBCM/SBTM Rio de
- Janeiro, Brazil.

IFSHT MEMBERSHIP

- Full members: 37, representing more than 9500 hand therapists worldwide. Greece reinstated
- Associate members: Bangladesh, Mexico, Nepal, Philippines, Qatar, Singapore, Thailand, and United Arab Emirates.
- Corresponding members: Bahrain, Barbados, Gaza, Ghana, Iran, Malta, Romania, Saudi Arabia, Sri Lanka and Zimbabwe.

Regional Liaison Organisations: American Association for Hand Surgery (AAHS), Asia Pacific Federation of Societies for Hand Therapy (APFSHT), European Federation of Societies for Hand Therapy (EFSSH), International Federation of Societies for Surgery of the HAND (IFSSH) and International Society for Sport Traumatology of the Hand (ISSPORTH) and South American Society Hand Therapy (SSTM).

COMMUNICATION

Within IFSHT:

- Executive committee:

- Continue to chair regular Skype-call meetings, and use Teamworks as our virtual office
- Have been working closely with secretary general to ensure goals achieved and queries addressed.
- Prepared the budget for 2019-2022, allocating funds for major website update

- Committee activity:

- Education committee: has completed a survey of full members investigating society activities, and also asked associate/corresponding members for their needs to aid development
- Ad Hoc Social Media Committee has posted updates about IFSHT and the Congress in Berlin
- By-laws Committee has made some updates, especially to reflect deletion of commercial membership category
- Translation committee: now translating IFSHT Update into Japanese and Spanish.

- Delegate communication:

- Delegates continue to receive regular updates from the IFSHT Secretary General and vote electronically in IFSHT elections.

With Hand Therapists around the world:

- IFSHT Update: published 4 x annually in the US and the British Journals of Hand Therapy and distributed to all member countries. Now included in the IFSSH Ezine.
- IFSHT website (www.ifsht.org): Continue to regularly update website with new features and content. Over 300 requests for hand therapy information, education, international referral for patient care received over last three years.
- IFSHT Hand Therapy Connections E-Newsletter: 2x per year. Currently, 1937 subscribers.
- IFSHT Facebook: remains active

IFSHT contribution to IFSSH E-zine: IFSHT has continued to source and prepare a short clinically relevant article for the IFSSH Ezine. Recent topics include splinting for thumb MP joint hypermobility.

IFSHT AWARDS AND SPONSORSHIP ACTIVITY

- Evelyn Mackin Award: sponsorship of a therapist(s) from a developing country to attend triennial congress. In 2019, IFSHT fully supported four therapists to attend the congress. Therapists were from Bhutan, Zimbabwe, Estonia and Poland. IFSHT has booked and paid for flights, accommodation and registration in full.

- IFSSH/IFSHT Triennial Congress Travel Grant: Eighteen applicants received funds to support, registration, accommodation and/or travel. Funds were distributed based on guidelines, specifically for countries with low GDP, for associate members who had not attended the Congress previously, with funds from the 2016 Silent Auction specifically used to support speakers and poster presenters.

- IFSHT-IFSSH International Hand Therapy Teaching Awards. During this term, grants made available to support therapists teaching hand therapy in less-developed countries have increased to $US1500. Four applications were received and support offered to:

- Jane Fedorczyk (USA) travelled to Rwanda in April 2018 (funds not required)
- Jenny Ball (Australia) travelled to Nepal in May 2018
- Meryl Glover (UK) travelled to Malawi in October 2018
- Shrikant Chinchalkar (Canada) travelled to Sri Lanka in February 2019

- Cristina Alegri Award for Innovation in Hand Therapy will be awarded at close of innovation session on Friday. Eight worthy nominations were received.

- The inaugural IFSHT Lifetime Achievement Award will be awarded in 2019 to honor those who have made a global impact on profession of hand therapy. 13 recipients will receive award at IFSHT opening ceremony on Tuesday 18 June.

- Dynamometers: ~15 available. Since June 2018, delivered to Nepal, Bolivia, Tanzania, Rwanda, Zimbabwe, India, Vietnam, Malawi, Argentina, Kathmandu by visiting therapists.

Outcome measurement in hand surgery

"If you can't measure it, you can't improve it" - P. Drucker

This article provides an overview on why and how data can help to improve high-quality patient care in hand surgery. It summarizes the most common patient-reported outcome measures (PROMs) that can be used in daily practice and for studies. Furthermore, it focuses on how to interpret PROMs data and shows that several clinically relevant interpretation methods are available, regardless of the statistical p-value.

Why outcome measures?

Without measuring treatment outcome, we can neither improve our hand surgical interventions nor demonstrate their effectiveness. Although some interventions have been proven effective and safe for a certain patient population, this does not necessarily mean they can be applied to patients in another clinical setting. Therefore, standardized documentation of outcomes is essential not only in studies, but also in clinical routine. For the latter, documentation is best realized using registries. Large registries in hand surgery are rare. Unlike in orthopedics, where such registries have a long tradition, hand surgical data are only now being collected on larger scales in a small number of countries.

These big databases are required to gain more evidence about interventions that is statistically sound and represents a real-world setting. Registry data may be considered advantageous over results stemming from individual and somewhat restricted clinical trials.

Overall, outcome measurements help to quantify patient benefit and the effect of a new intervention compared to established procedures. They can also help in identifying remaining deficits after interventions as well as the associated socio-economic consequences. In the modern world with its increasing health costs, outcome measure data can form the basis for negotiations with health authorities. Ultimately, we would also like to know just how our patients are really doing.

Most commonly used patient-reported outcome measures (PROMs)

A wide variety of outcome measures are available for assessing hand conditions. A literature review analyzing a series of studies focused on treatment for trapeziometacarpal osteoarthritis, for example, revealed that there were 21 different questionnaires in use.[1] Similar findings have been reported for Dupuytren studies, whereby only 14% used validated PROMs[2]. The diversity in reporting outcomes makes it difficult to compare results between studies. Table 1 highlights the most common and validated PROMs for patients with different hand conditions.

The Disabilities of the Arm, Shoulder and Hand questionnaire (DASH) or its shortened form, the quick DASH[24,25] is missing here. Why? The DASH is still the most commonly used questionnaire in hand surgery, and several studies attest to its good measurement properties[26-29]. BUT: The DASH is intended to measure function of the entire upper extremity and not just the hand. The questionnaire contains items relevant to shoulder and elbow function that significantly influence the total score. Therefore, it is recommended to use a hand-specific questionnaire for the primary evaluation of hand surgical procedures. The DASH might still have its place, for example, in more complex disease patterns such as rheumatoid arthritis, where the whole upper extremity is involved and the effect of a single intervention on global function requires evaluation.

Core sets

Outcome measures should cover all domains of interest to comprehensively assess the health status of a patient. For example, the dimensions of objective data (clinical measures, radiological criteria), functional outcome (hand and extremity specific) and patient-rated subjective data (quality of life, function and pain) together with socio-economic data and comorbidities are of interest. This implies the use of many different outcome measure tools, which may contribute to a high administrative burden for both the health-care provider and patient. If available, core sets assessing the clinical and patient-reported outcomes as well

Table 1: Most common and validated PROMs for patients with hand conditions

Name	Target population	No of items	Domains	Pros / Cons
MHQ3-10	All hand conditions	37 items	Six subscales: overall hand function, activities of daily living, pain, work performance, aesthetics, satisfaction	Pros: Good measurement properties, scores both hands separately, subscales can be scored individually Cons: Quite long
Brief MHQ8,11-13	All hand conditions	12 items	Six domains: overall hand function, activities of daily living, pain, work performance, aesthetics, satisfaction	Pros: Good measurement properties, short Cons: Subscales cannot be scored individually
URAM14-16	Dupuytren's disease	9 items	One domain measuring functional disability of patients with Dupuytren's disease	Pros: Good measurement properties, specific for patients with Dupuytren's disease, short Cons: Not suitable for other hand conditions
BCTQ / Levine Scale17-19	Carpal tunnel syndrome (CTS)	19 items	Two subscales: symptom severity scale, functional status scale	Pros: Specific for CTS, good measurement properties Cons: Not suitable for other hand disorders, potential item redundancy

MHQ = Michigan Hand Outcomes Questionnaire; URAM = Unité Rhumatologique des Affections de la Main (URAM) scale ; BCTQ = Boston Carpal Tunnel Questionnaire ; PRWE = Patient Rated Wrist Evaluation

as complications should be used, such as the already established core sets for assessing patients with distal radius fractures[30] or hand osteoarthritis (OA)[31].

Some recent projects are concentrating on the establishment of a minimal data set to evaluate subjective outcome with only a small number of relevant questions. In the fields of the lower and upper extremity as well as spine surgery, this approach has proven successful. A 6-item "Core Outcome Measures Index" questionnaire developed for patients with spine, hip and knee disorders[32-34] and the 1-item "Single Assessment Numeric Evaluation" tool for patients with shoulder disorders[35] both comprise a minimal data set that delivers useful information on the treatment outcomes. Such a short, multidimensional tool could also be applied in hand surgery. It could even serve as a preoperative evaluation tool to determine the patient's needs and expectations, which may in turn help to improve the indication quality for different therapy options.

Statistical versus clinical significance

The interpretation of study results is traditionally based on statistical significance. However, a statistically significant treatment effect does not necessarily equate to a meaningful outcome for the patient[36,37]. The patient's perception of a treatment effect is important and should be considered in every instance of clinical care.

"Based on the p-value ≤ 0.05, we conclude that our treatment was effective". In research articles, we often encounter this kind of statement. However, is this statistical effectiveness directly related to that perceived by the patients themselves? To answer this question, one should take a closer look at the characteristics of p-values. The American Statistical Association (ASA) highlights the common issues with p-value. A small p-value often induces an inappropriate conclusion that a large treatment effect was achieved[36]. However, a p-value provides neither a direct measure of the magnitude of a treatment effect nor describes the importance of the results. The calculation of a p-value is based on the sample size. The larger the sample size, the more likely a statistical analysis will result in a "significant" p-value regardless of whether there was only a small treatment effect. In contrast, "significance" may probably not be attained with a small sample size, although a large treatment effect is apparent[36]. Therefore, alternative interpretations of treatment effects based on clinical relevance have become increasingly popular[38,39]. There are three underlying concepts that measure this aspect:

1. Minimal Important Change (MIC)

The minimal important change (MIC) is the smallest change in a score, which patients perceive as important. This outcome considers any change within a single group or patient[40,41], and changes exceeding the MIC can be considered relevant for the patient42. A related term known as the minimal clinically important difference (MCID) is also widely described in the literature. Several studies defined the MIC for various outcome measures in hand surgery[13,43-48]; for example, the MIC for the Michigan Hand Outcomes Questionnaire (MHQ) is 11 points[47].

2. Minimal Important Difference (MID)

The minimal important difference (MID) is the smallest difference between patients or patient groups that is considered important[40,41]. In hand surgery, the MID has only been characterized for the Unité Rhumatologique des Affections de la Main (URAM) scale in patients with Dupuytren's disease and is 8 points[44].

3. Patient acceptable symptom state (PASS)

The patient acceptable symptom state (PASS) is the value beyond which patients consider themselves well[49]. This value has been determined for the quick DASH in patients after carpal tunnel decompression (PASS ≤ 34)[27]. In patients with hand osteoarthritis, PASS values are defined for the Australian/Canadian (AUSCAN) Hand Osteoarthritis Index (PASS ≤ 43)[50], pain numeric rating scale (PASS ≤ 1-5 - 4.1)[12,51] and the brief MHQ (PASS ≥ 64)[12].

Example: Interpretation of study results

To illustrate the difference between statistical and clinical relevance, we simulated two studies with the brief MHQ score as a representative outcome parameter to assess a treatment effect. The score ranges from 0 to 100 points with 100 denoting the best hand performance. In the first simulation with data from 10 patients, the mean baseline score of 53 (standard deviation [SD] 6) increased to 64 (SD 11) at the post-treatment follow-up examination (Figure 1a). The resultant p-value of 0.07 implies that there is no significant treatment effect. However, the mean score change of 11 points corresponds to the established MIC perceived by patients. As a result, we can conclude that the treatment is indeed effective from the patient's perception.

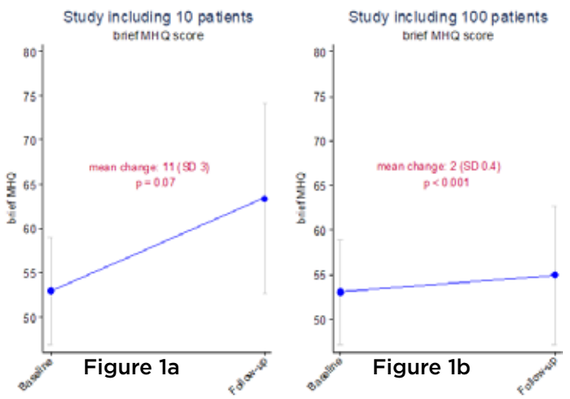


Figure 1a: Brief MHQ score in a simulated study including 10 patients. The mean change between baseline and follow-up is 11 (SD 3) points with p = 0.07 (Wilcoxon signed-rank test).

Figure 1b: Brief MHQ score in a simulated study including 100 patients. The mean change between baseline and follow-up is 2 (SD 0.4) points with p < 0.001 (Wilcoxon signed-rank test).

In contrast, the baseline brief MHQ score of 53 (SD 1) was similar after treatment (55 [SD 1]) for the second study simulation including 100 patients (Figure 1b). Although the calculated p-value of less than 0.001 indicates a highly significant improvement, the mean change of only 2 points suggests the lack of a clinically relevant treatment effect.

Despite the patient-centered approach, MIC/MID/PASS values cannot stand alone. Statistical tests should undoubtedly be performed to prove the effectiveness in adequately powered studies. In addition to these tests, information about the magnitude of change based on effect sizes and confidence intervals should be provided.

Summary and Outlook

In summary, measuring the outcome of a specific treatment is crucial to improve patient care. Patient-reported outcomes are indispensable and, if possible, joint and disease specific questionnaires should be applied to avoid response bias due to the application of global questionnaires. Furthermore, the use of core sets or minimal data sets is favorable to provide data that are comparable in systematic reviews and meta-analyses.

The interpretation of study results should not only rely on p-values, but also consider the effect that is relevant to the patient. The MIC and PASS are useful tools to interpret the outcome of individual patients during clinical routine, to appraise study results and for sample size calculation.

During clinical routine, the surgeon can judge if treatment had a subjectively important effect for the patient and if the patient is satisfied despite potential residual symptoms. For the interpretation of study results, knowledge of the MIC and PASS is crucial to look beyond the p-values, which do not consider the magnitude of a treatment effect and are dependent on the sample size.

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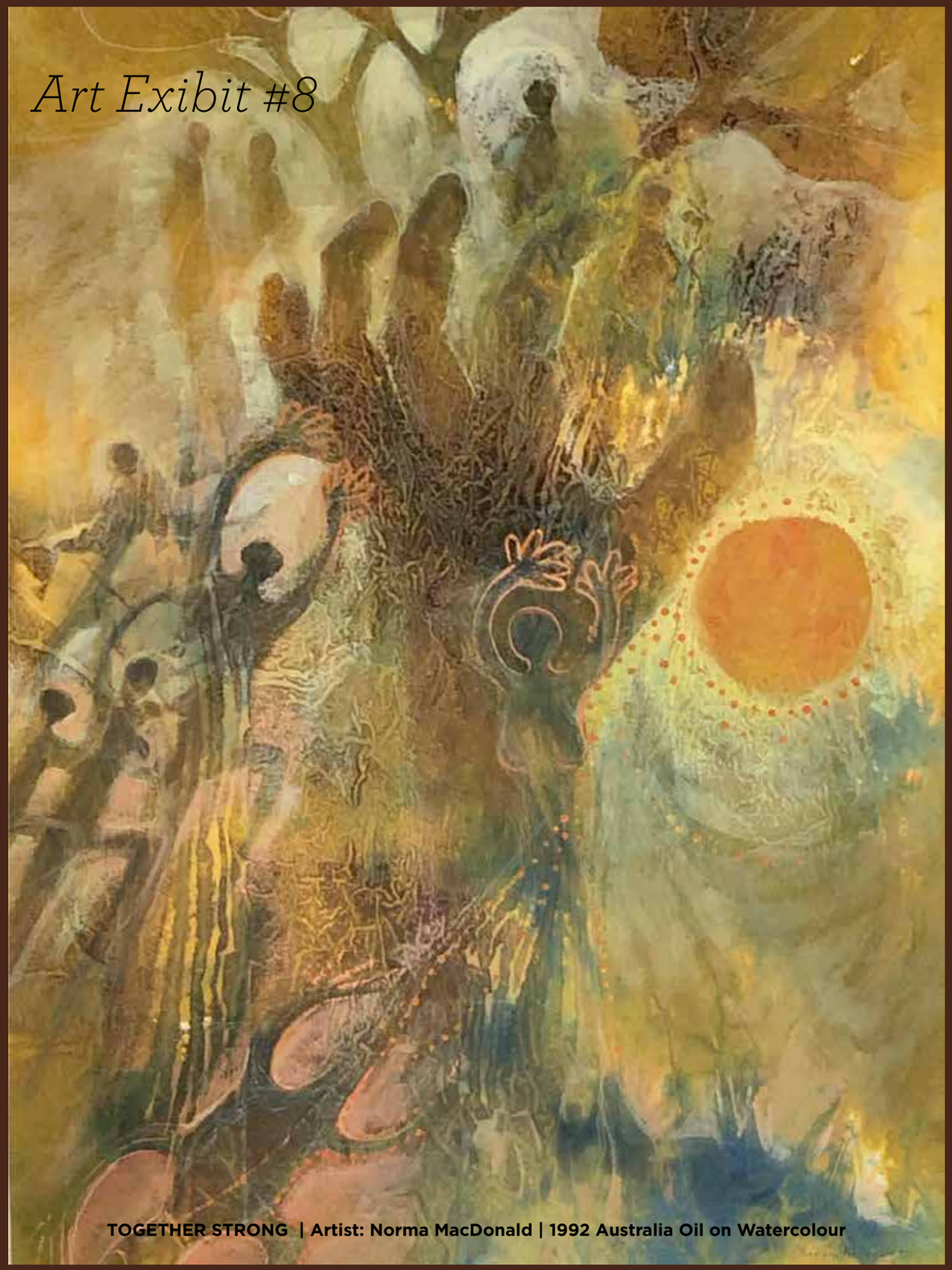

TOGETHER STRONG | Artist: Norma MacDonald | 1992 Australia Oil on Watercolour

Reflex Sympathetic Dystrophy (RSD)/CRPS/ SUDECK does not exist

"Eppur si muove" G. Galilei.

Introduction

The beginning of the end:

- Preliminaries
- The literature.
- The recognition that Pain Clinics are graveyards.
- The lack of knowledge/CRPS ratio.
- The Budapest criteria

- **The importance of "Irritative CTS".**
- **The series: 100 patients diagnosed with RSD**
- **The aftermath.**
- **Conclusions.**

This essay was prompted by a letter from Professor Mennen, Editor of Ezine, asking me to update the Editorial I wrote in the Journal of Hand Surgery European Volume.

This paper is about my extreme scepticism in the existence of the Sudeck atrophy, also known as reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS). The name for this diagnosis varies depending on the age of the surgeon, their background, and their country, but they all describe the same: an abnormal painful response after trauma or surgery, accompanied by vasomotor changes, at least in the early stages, and the lack of a plausible cause for its development.

I was emotionally moved, when Professor Mennen wrote: "Your "message" is very important because so many patients are unfairly labelled [with the diagnosis of CRPS1] often because of doctors' slapdash diagnosis-making, ignorance or incompetence" (see also: IFSSH Ezine, Volume 29, February 2018, Editorial, "Checklist for Holistic Management"). I cannot agree more with this statement and the important truths it bears on our profession. In many cases diagnosing a patient with CRPS is tantamount to labelling them as a pariah. It is known that some doctors will refuse to see any patient with this diagnosis. Even worse, are the iatrogenic and psychological consequences of this diagnosis to the patient: [2-4] nocebo effect, medicalization, addiction to opioids and psychotropic drugs, personality changes, low self-esteem, catastrophic thoughts, etc. Many of these medications and therapies make it increasingly difficult to reverse the process. My second concern about this diagnosis is that it often is the end result of poor doctoring; in most cases rigorous physical exam and listening to the patient will elucidate the true mechanical or physical source of their pain.

In this report I will describe the process which drove me into playing this Quixotesque role of placing my reputation on the line at every meeting for the sake of debunking this diagnosis once and for all. As a matter of fact, by the time this writing comes out I may have already been burnt on a stake, as I will have delivered my Invited Keynote Speech before the American Society for Surgery of the Hand on my findings on RSD. However, like Galileo, who when before the Inquisition Tribunal and pressed to renounce his thoughts publicly, mumbled ""Eppur si muove" (yet it moves)", I too will stand and say out loud: RSD/CRPS1 does not exist.

THE BEGINNING OF THE END:

Preliminaries

I consider the whole condition named RSD-CRPS1-Sudeck, to be a complete fabrication. In my view, it is a very convenient "trashcan" diagnosis, where all pain complaints that we do not understand can be placed. The patient with this "syndrome" is sent away from the surgeon to Physical Therapy (and later to the Pain Clinic). In this manner, we surgeons, get rid of the problem, of the patient, and we can continue sleeping happily feeling we could not have prevented the problem. In other words, the source of chronic post-operative pain can be blamed on RSD, and, of course, on the patient, who is the ultimate person responsible for being so sickly that they develop this condition. Let's stress from the beginning that many of us think that there is something very suspicious about the whole concept. However, since everybody accepts it, we play what in psychology is called the bystander effect: "if nobody is willing to do anything, why should I?"[5]

The origin of CRPS is confusing, but it began 150 years ago when Silas Mitchell, a neurologist, described the burning pain and vasomotor changes soldiers had in their limbs after sustaining major nerve trunk injuries. The condition was named causalgia and it had an evident inciting pathology - a nerve injury. This initial concept was distorted by Paul Sudeck in 1900, who extended the condition to cases with similar clinical picture but caused by minor or even a non-traumatic event (minor causalgia). Later, Leriche and Policard would attribute over activation of the sympathetic nervous system as for the pathology resulting in the unusual clinical picture. It is difficult to determine when and how this totúm revolutum ended up in what we know today as RSD/CRPS1/Sudeck. But even with today's medical advances,[6,7] this "condition" has no consistent clinical picture, no specific diagnostic tests, an unknown pathophysiology, and lacks pragmatic curative treatment. Surprisingly, with such a meagre pedigree, it commands a major place in the medical literature. It is backed by no fewer than 6000 papers in a simple PubMed search and hundreds of chapters in reference books.

Indeed, it is remarkable that now, in the current trend of precise scientific virtuosity, when there is adoration for statistics versus observation; now, when anything published in any of the "reputed" journals has to be proved, doubly tested, doubly blinded, and doubly wrapped in numbers; precisely NOW, it so happens that this condition survives, as concocted more than 100 years ago, purely thanks to our blind adherence to long-established tenets, with no scientific foot to stand on. Is this not concerning?

To be fair, the condition has been not totally static since its inception by Mitchell, Sudeck and Leriche. Some years ago, the terminology and taxonomy of reflex sympathetic dystrophy were revised in order to dodge the lack of sympathetic system involvement.[8] The new terms are complex regional pain syndrome type 1 (CRPS type 1) and CRPS type 2.[9] Both CRPS 1 and 2 shared symptoms and signs, but while in type 2 there is an injured nerve, in CRPS1 no nerve injury can be recognized. Thus, reflex sympathetic dystrophy (RSD) and Sudeck is parenthetically retained for CRPS type 1 and causalgia is in turn maintained for CRPS type 2.

Although in this paper I will refer more to CRPS1, I will unavoidably discuss both, as CRPS 1 and 2 are often mixed in the literature, share core diagnostic features, and hence, make the distinction quite elusive at times.[10,11] From the beginning I should remark that true CRPS 2 (causalgia) is a different animal from CRPS1: it has an underlying pathology (a damaged nerve),

surgical treatment, and often a cure.[12,13] Conversely, CRPS1, which is (still) mainly considered a sympathetic mediated problem, has a medical approach with variable success and low-quality evidence to support any of the recommended treatments: [14] stellate ganglion blocks (repeated as needed),[15] sympatholytic drugs, opioids and drugs for neuropathic pain (anticonvulsants/antidepressants), bisphosphonates, steroids, free-radical scavengers, among many others. [6,7,15-20]

I should stress, that despite the fact that the condition has a main place in medicine, prominent surgeons and neurologists had already expressed their concerns on the overuse of CRPS as a diagnosis.[8,21-24] Championed by Dr Kasdan, some realized that behind many CRPS cases were the so-called psychogenic-hand.[25,26] Zhu, Jupiter, and Jones[12,13,27] pointed out that some forms of causalgia (presently known as CRPS 2) could be treated surgically offering a solution to patients with excruciating pain where a nerve had been insulted.[10,28]

As early as 1962, Stein[29] linked some forms of Sudeck to compression of the median nerve in the wrist. Later on, several studies favor the same approach for patients who have positive neurophysiological studies.[11,30-32] Finally, Dr. Dellon deserves a main seat among these pioneers, and although his body of work has been devoted to the lower limb,[24,33] his focus on the nerve as the root cause of this condition has also been applied in the upper limb.[34]

Is the literature always right?

We are all influenced by the literature and what has been written weighs heavily on any change. No one wants a rumpus in their Journal. Not surprisingly in my Editorial in JHSE,[1] the Editor-in-chief added a note saying that the journal view was to accept CRPS as a condition.[35] However, one of my mentors, Ian Jackson (a top craniofacial surgeon at the Mayo who, to my surprise and fortune, pupiled me very early on in my career), took me aback by saying: "Only stupid people believe everything that has been written". He was so right! There are plenty of examples even in recent medical history. Let's remember that the highest impact journals, i.e. New England Journal of Medicine, Lancet, JAMA, Annals of Surgery and many others, have supported the benefits of vagotomy for peptic ulcers for generations, yet we all know that the whole idea was "fake news".

For CRPS the literature has undergone constant adaptation to the results which demonstrated that a previous theory explaining and justifying CRPS was wrong. Just think for a moment that the role of sympathetic system in RSD was dismissed, once well-performed randomized studies proved that a placebo was just as good as the sympatholytic drugs.[8,21] Aggressive treatments such as phenol, were met with at best no effect or at worst the painful sympathalgia.[36] The promising spinal cord stimulation[37] could not stand the test of time,[38] and, so on, for the steroids, or any drug you can imagine. Even in recent reviews of the topic on RSD: [6,7,15,16,18,20,39] "could", "should", "perhaps", "at times", "often", "frequently", "seems", "may", "guess", "suppose", "theorize", "surely", "accept", "classically", "commonly", "probably", "suggest", "speculate"…"often are, but also may" are the strongest scientific terms the different authors use to support their conclusions. Could the diagnosis be a fabrication? (Figure 1).

The recognition that the Pain Clinics are graveyards

Again, many clues come by chance. I had a patient who, having been in the Pain Clinic with the diagnosis of RSD for 10 years following a minor crush to his thumb, came for another opinion. I found he had a glomus tumor, which I treated and cured. As I used to live in a small town where everybody bumps into each other, when I ran into the pain doctor whom I told, quite excitedly, that I had successfully treated a patient of his who had been diagnosed with CRPS. He replied, somewhat offended: "My role is not to know what the patients have but to ease their pain"….and he was right, but he also gave me a most important clue for my future: once you are in the Pain Clinic nobody is going to help you to get out of there.

The lack of knowledge/CRPS ratio

After this very first patient I began to see more and more patients diagnosed with RSD and, in most, I was able to find the cause and treat them successfully.

This was astonishing as by definition a patient who has been labelled as CRPS has no treatable cause for their pain. I also noticed that most cases came from surgeons whom I knew not to be the most knowledgeable (Figure 2). Without doubt, behind these alarming numbers there was a need to get rid of "annoying" patients who would be condemned to the Pain Clinic - to the graveyard- with no hope in sight.

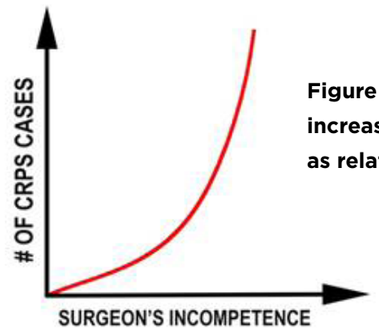

Figure 2. Exponential increase of CRPS cases as related to ignorance

Table 1. Budapest Criteria for CRPS (Harden at al., 2010)

AT THE TIME OF EXAMINATION THE PATIENT MUST REPORT:		
1. Continuing pain	disproportionate to inciting event	
2. Symptoms	at least 1 in 3 of the following 4 categories:	
	Sensory	hyperaesthesia/allodynia
	Vasomotor	temperature/ colour changes - assymetry
	Sudomotor	oedema/sweating changes - assymetry
	Motor / Trophic	deceased ROM. weakness tremor/dystonia trophic changes in skin, hair or nails
3. Signs	at least 1 in 2 of the following categories:	
	Sensory	hyperaesthesia to pin prick Allodynia to light touch
	Vasomotor	evidence of temperature/colour assymetry
	Sudomotor	evidence of oedema/sweating assymetry
	Motor / Trophic	evidence of deceased ROM, weakness tremor/dystonia, trophic changes to skin, hair or nails
4. No other diagnosis explaining symptoms and signs		

Weaknesses of the Budapest criteria

But why was it possible for a surgeon to label a condition as being CRPS if it had a treatable cause? How could we make a diagnosis that has such an enormous impact on a patient's well-being so frivolously? The reason was, without a doubt, that the criteria applied to diagnose CRPS were extremely indistinct and biased: anything would fit (Table 1).[40] Specifically, pain (criteria 1) was subjective, and criteria 2 and 3 were shared by trauma, inflammatory conditions, ischemia, etc, and were thus quite unspecific. However, the most unfair of all diagnostic criteria, and the one which later proved to be the main "sinkhole", was item 4. Criteria 4 left to a doctor's discretion which patient they felt had an unknown condition. As I already pointed out in my former editorial, "The only person who should reliably state that there is not an overt organic cause for a patient's pain should be the specialist in the field i.e. a Hand Surgeon". The rest do not have the knowledge and understanding to label a patient with CRPS. But even in the realm of hand surgery, do we all know the same?

THE IMPORTANCE OF IRRITATIVE CTS

The recognition that I could successfully treat patients labelled as having RSD by fellow surgeons/doctors, and the direct relationship to their lack of knowledge, triggered in my mind the following "anti-establishment" thought: "If only we all knew all the facts, RSD/CRPS/Sudeck would not exist". I, hence, became obsessed trying to understand what these patients really had. It was clear that some had factitious issues, others had sustained a nerve trauma (Causalgia/CRPS2), and a large group had suffered from bad-doctoring. But, what about the rest?

I am not sure exactly how and when I realized that the complaint of worsening of symptoms at night reported by some CRPS patients was the clue in the remaining cases. The only condition that I knew to produce this was compression of the median nerve in the carpal tunnel. However, these patients labelled as CRPS had a very different picture from a classic carpal tunnel syndrome (CTS): pain and numbness away from the median nerve territory, swelling, stiffness, burning pain, etc (Figure 3).

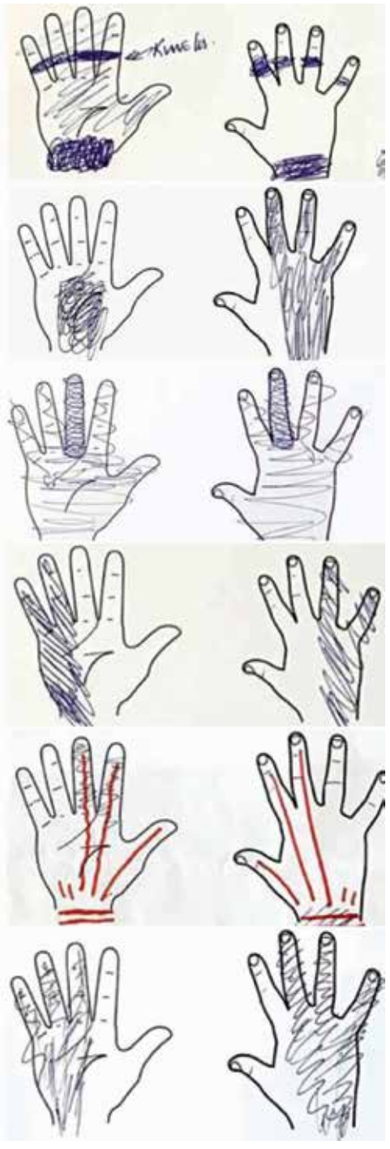

Figure 3. A sample of charts of my ongoing study, showing the area of allodynia-dysesthesias in the hand reported by the patients (marked). Note that most had more symptoms in the ulnar nerve territory, some in a glove distribution and few in the median nerve territory.

As always, most responses could be found in the literature. It has been long known that brachialgia or even more proximal pain, can be originated by compression of the median nerve in the carpal tunnel, and that by releasing the ligament the pain disappears.[41,42] Swelling has not been considered a prominent feature in CTS, yet Burke et al. have proved it to be a most prevalent symptom in idiopathic CTS.[43] The works of Ochoa and others opened my eyes and helped me to understand that the median nerve could cause pain in the ulnar nerve territory, proximally or even simulate an acute myocardial attack.[10,44] Furthermore, Bennett and Xie[45] demonstrated in rats that nerve compression triggered a clinical picture similar to a CRPS1. This assured me I was very much on the right track: the median nerve. Nevertheless, I still needed more evidence.

Currently, any ground-breaking change in our practices, or any new condition, is accepted only if accompanied by objective data, statistics and "evidence". Albeit good, we should not forget that observation has contributed enormously to the progress of Medicine. Through observation, Fleming realized that penicillium had a bactericidal effect. Through observation, syndromes such as "partial thenar atrophy" and "acroparesthesia" (derogatively known, as it affected mostly women, as "hysterical nocturnal paresthesias" – these were certainly pre #metoo days) were linked together, giving birth to a new condition: the ultrafamous carpal tunnel syndrome (CTS).[46] It is astonishing to realize that the most common operation a hand surgeon performs today, carpal tunnel release (CTR), was unknown until 1950. Thousands of patients have benefited from this important understanding - simply based on observation.[47,48] Before this linkage several "treatments" for idiopathic CTS patients had been recommended: quinine, iron, arsenic, morphine, strychnine, henbane, galvanization of the hands with interrupted and continuous current, Phenobarbital and Bromide combined with a vasodilator, and rib resection, among many others.[46] To sum up, all these advances, and so many more in the History of Medicine, were thanks to observation, presently reviled by the scientific methodology.

Through observation we noticed that a group of patients who had "compression" of the median nerve, did not display the typical CTS signs and symptoms. Chief complaints were pain and tingling in the median nerve distribution (but often not limited to it), worsening of the symptoms at night, swelling, and, above all, inability to make a full fist (Figure 4). Those were exactly the same signs and symptoms a very different group of patients displayed. The latter were all patients with previous trauma to their hands and who had been labelled and treated for CRPS prior to referral. Both groups were indistinguishable clinically and both were treated with carpal tunnel release (CTR). In no case were continuous axillary blocks, sympatholytic medication, or stellate ganglion blocks given after the surgery. Light painkillers (paracetamol orally) was prescribed as per our usual protocol for patients who have idiopathic CTR. The response and outcome to surgery was indistinguishable. We named this new condition irritative carpal tunnel syndrome, as the median nerve seemed to be irritated rather than

Figure 4.

compressed. I should stress that these patients were operated disregarding their nerve conduction studies which were negative in 2/3 of those whom were asked.

Figure 4. Severe form of bilateral irritative carpal tunnel syndrome. In both pictures, the patient is being asked to make a tight fist. On the left, he is shown preoperatively, on the right he is shown in the OR after bilateral CTR under local anesthesia. No antecedent trauma could be recalled.

THE SERIES: 100 patients with the diagnosis of RSD

Irritative carpal tunnel syndrome was the missing link I was looking for to be able to come full circle!!!

To confirm that I was right, I studied a cohort of 100 consecutive patients who had come to the office with the diagnosis of RSD. (It took me more than 4 years to gather the first 25 patients, but once I had appeared on the national news dealing with this topic, I gathered the remaining 75 in less than a year). Briefly, the preliminary data shows that ninety-five percent had been diagnosed with RSD by a physician (surgeon or rehabilitation doctor) and the rest by a therapist. Ninety percent had been treated in a pain clinic. Ninety-three percent were on opioids and/or psychotropic medication, one for more than 15 years. The remaining were on painkillers and steroids. All had pain, sense of stiffness and/or limited range of motion.

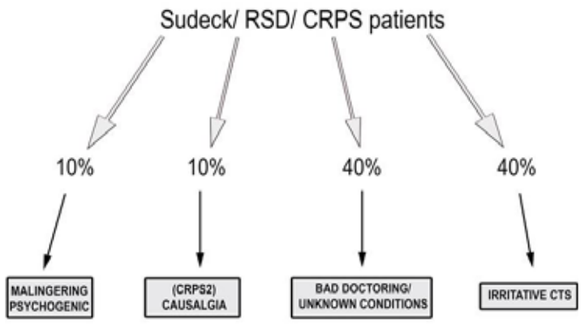

Figure 5: True allocation of the patients diagnosed with Sudeck's in this study.

The general results can be summarized in the chart below (Figure 5). Note than in nearly half, bad doctoring was behind the scenes: ignorance or overt malpractice masked by the CRPS/RSD acronyms!!

The psychogenic-hand patients were advised to go to a psychiatric consultation with little success. Five patients did not require any surgical treatment, but support in PT and were weaned off drugs. I open here a parenthesis to stress that it is not uncommon for some patients to develop, after surgery or trauma, what I was taught to be a "flare reaction". The clinical picture appeared some weeks after the trauma/surgery and shared the same symptoms and signs as a CRPS1. The problem cleared up with PT and reassurance. Now, due to abuse of the diagnosis of CRPS and the laxity of the criteria,[18,40] some flare reactions can be misinterpreted as CRPS - dragging the patient into the pernicious effects of such a misdiagnosis.[2-4]

Nearly half dismissed any operation on the grounds: "my doctor advised me against surgery", "my doctor told me you are only interested in operating on me to make money" and "the literature is against surgery", yet they had treatable conditions. The oversighted pathology was at times embarrassing (Figure 6).

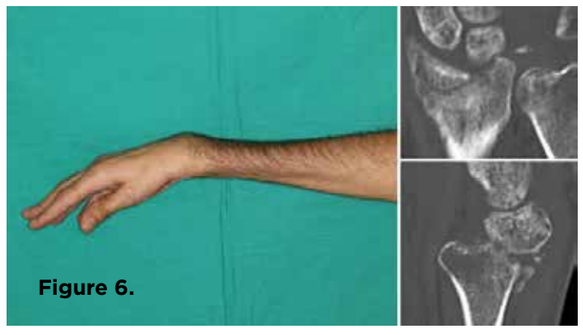

Figure 6. This 34-year-old male diagnosed with Sudeck had neuropathic pain, anesthesia in the median nerve territory, and a frozen hand. He had sustained a motorbike accident which required a week of ICU admission for abdominal and head trauma. The wrist was placed in a (tight?) cast. The CT scan shows the status of the wrist at his very first visit, 3 months after the accident. The malunion was aggravated by a concurrent Volkmann and intrinsic muscles contracture. Surgery was advised but the patient declined, arguing that his treating doctor had stressed to him that any surgery in a Sudeck patient would harm him. Instead, a 4-month course of PT and psychotropic medication were recommended. He was lost to follow up after this "confrontation".

Those who had surgery had their problem solved all bar one. This specific patient remained unhappy due to stiffness. Her pain was rated during physical therapy as 8 over 10 in a VAS (0-10). Nevertheless, her pain at night and daytime dropped from 10 to 0 at the six month follow up. This particular patient had a metastatic lung cancer and was undergoing chemotherapy. She developed shoulder and wrist pain after having been operated on for a wrist fracture. It is worth stressing that those with Irritative CTS were operated on disregarding their nerve conduction studies which were negative in a significant number of those whom were asked.

To summarize, by keeping the categorization chart in mind, no patients were to be labelled as RSD/CRPS1/ Sudeck.

THE AFTERMATH

TThe birth, or the death, of any condition or assumed treatment is, inevitably, surrounded by controversy. Recently, we have witnessed the death of vagotomy in peptic ulcer management, despite a wealth of supportive literature in high-ranking journals.

In my Quixotesque role to kill this condition, I am not alone - I am standing on the shoulder of giants, surgeons and neurologists,[8,10-13,21-34] whose keen eyes have been cornering the condition: psychogenic hand, causalgia (CRPS2) were but a part of the picture. But this was not enough, there were some patients left out who had symptoms and signs that could be assigned to CRPS. My background as a wrist and microsurgeon allowed me to spot structural bad-doctoring as the root cause of many CRPS cases. The final piece to the jigsaw was noting that the median nerve could be irritated without being compressed, thus frequently the standard neurological studies were non-contributory. More than 40 patients have been operated on for irritative CTS (Figure 7) and all except one, aforementioned, responded. Whether she had an "unknown condition", a psychogenic hand, or a grievance because of her underlying medical condition, requires further study. In this respect, patients who do not improve after a rigorous search for the cause or after failed surgery, might need to go to the Pain Clinic. This must always be under the supervision of the treating surgeon. For sure, the Pain Clinic should not be a graveyard of discarded patients, but the place where patients are to be treated temporarily, while the root cause of the problem is sought out and solved.

Figure 7. This patient was seen 8 months after sustaining a DRF treated in a cast. No malalignment existed on the X-rays. Nevertheless, she developed pain and swelling that required intensive PT and treatment in the Pain Clinic (see patient's picture on the left at 5 months with persisting swelling). On her first visit, despite being on gabapentin, lidocaine patches/opioids she rated her pain as 8 (on a VAS:0-10) and could not make a fist. Five weeks after CTR under local her pain was 0. She returned to work as a housekeeper in a hotel.

But do not get me wrong, the problem is not solved by simply releasing the carpal ligament. In fact, doing so, can even be detrimental: there are many

factors in play. Just as when recognizing a factitious injury you get to know all possible answers,[25,26,49,50] the same applies for bad-doctoring. In about 40% of the cases there was a major medical error behind them (including inadequate carpal tunnel release in 15%). Co-existent shoulder pain and established stiffness interfere in the recovery and has to be addressed. Besides this, surely the percentages and root causes of CRPS cases vary in each surgeon's practice. As an example, this may be more a nerve problem in Dr. Dellon's office, more a mechanical cause in mine, and a mixed etiology in others'. We are currently looking for a test that could help everyone to spot a patient with a treatable condition. We are studying the small fibers which are the afferents for pain, burning sensation, and which dominate vasomotor effectors (Aδ fibers -small myelinated- and C fibers -unmyelinated). These fibers cannot be recorded by the standard neurophysiological tests (which study large –fast-conducting- myelinated fibers). Perhaps the so-called Sympathetic Skin Response test may prove useful.[51-52] Another avenue is functional brain MRI. With the latter, we want to sort out who has real pain, and how different this is in irritative carpal tunnel syndrome versus idiopathic carpal tunnel syndrome.

My final words go to the suffering patients who need our love and compassion. They have been wandering from one doctor to another and resemble zombies more than normal people. Very few are looking for a secondary gain, and indeed most are under the effect of multiple drugs and receiving no empathy. (I recently had, as a patient, an ICU doctor, who could not stop cursing the incomprehension she had been through before we tackled her problem). I cannot deny that there are patients whose characteristics may make us repudiate them from the very outset. But let's be rational. First of all, as they have already been subjected to a failed treatment, they will regard the new surgeon with suspicion and lack of confidence. Furthermore, those who have been in the Pain Clinic for a long period, have become addicted to several drugs, with personality implications (low self-esteem, passive-aggressiveness, uncoordinated discourse, among others). Typically, all of them have a very low threshold for pain and, because of their long use - and abuse - of drugs, they self-medicate setting their own rules much to our despair. However, after several days or weeks, once they start to feel better, they place their regained trust in their treating doctor and become the most cooperative, thankful and willing to help others that you have ever had. Love them, they need our love and care.

CONCLUSIONS: The amplifier effect.

If I were to condense all my research into a very simple theory, I should name it the "Amplifier effect". The term stresses that, much like the amplifier of a music system which multiplies the sound picked up by the needle of the turntable, the "damaged/irritated" nerve will likewise multiply the final pain reading in our cortex to the power of "n" (Figure 9). This theory may appear as unproven as others that have attempted to explain the physiopathology of CRPS. However, there is an important difference - this approach has pragmatically proved successful.

Another conclusion of this study is that CRPS1 and 2 are the same condition, the former with an "irritated" nerve (RSD, Sudeck), and the latter with a structurally damaged nerve (causalgia). Nevertheless, both are nerve mediated pathologies. Therefore, a more appropriate term for the whole clinical picture could be "Neural amplified pain". Patients without a nerve issue, have to be categorized as psychogenic hand, malingerers, victims of bad doctoring, and some early cases could fall into the so-called "flare reaction" pigeonhole. Finally, a minority may be ascribed to unknown conditions (1 in 100 in my series). If one adheres to these understandings, there will be no more mystery hidden in CRPS. More importantly, the patient will be properly allocated to a real condition, not to CRPS. Consequently, this will prevent unnecessary suffering and medicalization in all patients,[2-4] and above all in those most vulnerable.[53,54] I foresee that in contradiction of the current trend of rocketing numbers of CRPS1 cases (50,000 new cases per year in the USA),[55] removing the niche will reduce the incidence of the problem drastically in few years, as has already occurred in other unsubstantiated epidemics in our field.[56,57]

In closing, I beseech you to help me to wipe out this fabrication that leaves our suffering patients stranded in Pain Clinics around the globe. Our endeavor is paved with resistance, not only has the existence of RSD been engraved in stone in our minds, but stubborn opposition to new ideas is part of the human nature. I confessed in my Editorial[1] that I dreamed about the eradication of this pseudo-condition. Now that the enlightenment is so close, I admit that too often I awaken in the middle of the night and it takes me hours to fall sleep again because of the excitement of knowing that if I succeed I will have done more good than anything else I have produced in my life. Please help the progress of science by placing all your medical knowledge at the service of your next CRPS patient.

As a final caveat: It takes a small leap of imagination, that if I can debunk the whole CRPS concept in my terrain, the rest of the body will be open for others to deliver the final blow (a job already started by prominent giants).[13,33,58]

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Research Roundup

OUTCOMES FOLLOWING REPLANTATION/ REVASCULARIZATION IN THE HAND

Hoyune E Cho, Sandra V Kotsis, Kevin C Chung
"Hand Clinics" May 2019, Volume 35, Issue 2, Pages 207-219

1. What were your main reasons for writing this article?
The assessment of outcomes of replantation has not been standardized and has not applied sophisticated outcomes tools. We wanted to evaluate the evidence in current hand surgery literature and advocate for increased uniformity in the outcomes assessments, the type of outcomes measured, instruments used to measure, and the way they are reported.

2. What are the most interesting/important results and conclusions of your article?
The most interesting finding of our research is how there is so much heterogeneity in published articles, spanning from the type of amputation injuries included in the study cohort (digit type and level of injury, type of injury, severity of injury, etc) and outcomes reported (success/failure of initial revascularization, long term survival, functional outcomes assessed at different follow up periods, types of outcomes assessed, etc). The important conclusion is that the apparent variability of data makes it difficult for surgeons to draw any meaningful conclusions. We should strive to evaluate and report outcomes in a standard way.

1. What should all hand surgeons (and/or hand therapists) reading your article understand about the findings of your research?
We have provided in our article our recommendations for the essential components of outcomes evaluation following replantation in the hand (see table below). We need more studies to follow the guideline and produce comparable results, to synthesize accurate treatment guidelines. Then, hand surgeons can devise treatment plans that will best suit patients' needs and produce desired outcomes.

4. Will you be conducting further research/ publishing further work on this topic? If so, what will it entail??
Our team at **M**ichigan **C**enter for **H**and **O**utcomes and Innovation **R**esearch (**M-CHOIR**) has conducted many studies investigating outcomes after replantation in the hand. We are striving to generate high-quality evidence to help surgeons provide better care.

At this time, we have two large-scale studies ongoing. "**F**inger **R**eplantation and **A**mputatio**N** **CH**allenges in assessing **I**mpairment, **S**atisfaction, and **E**ffectiveness (**FRANCHISE**)" is an international, multicenter retrospective cohort study evaluating patients treated with revision amputation or replantation, with functional and patient-reported outcomes assessed at least one year after treatment. "Finger Replantation andAmputation Multicenter study (FRAM)" is also being planned at multiple sites both internationally and domestically in the U.S., with prospective collection of outcomes up to 1 year after revision amputation or replantation.

Outcome Domain	Parameters/ Measuring Instrument	Recommended Method to Assess and Report
Digit survival	Vascularity and digit viability	Assessed after 21 days postoperatively
Arc of motion	Total active motion	Sum of active range of motion at MCP, PIP, and DIP joints for each digit, measured with a goniometer
Sensation	2-point discrimination test	Shortest distance measured between 2 distinct points of touch by calipers
Sensation	Semmes-Weinstein Monofilament test	Smallest monofilament size detected by patient. Fibers must be perpendicularly placed and pressed onto the skin just to bend slightly.
Grip strength	Jamar hydraulic hand dynamometer	Handle position 2, patients sitting straight back, feet flat, shoulder adducted, elbow flexed at 90 degrees with forearm and wrist in neutral position. Strength should be measured in weight (kgs or lbs), and report should include the ratio between injured and uninjured side.
Return to work	Patient-reported	Capture patients' return to same job, different job, or unable to work
Complications	Cold intolerance, pulp atrophy, nail deformity	Present or absent, provider assessed with patient reports
Patient-reported outcomes	Patients' subjective evaluation of overall hand function, activities of daily living, pain, work performance, aesthetics, and satisfaction	Michigan Hand Outcomes Questionnaire (MHQ) and Disabilities of the Arm and Shoulder (DASH) questionnaire. Total and subsection scores, administered at multiple time points during follow-up

Table of the essential components of outcomes evaluation following replantation in the hand

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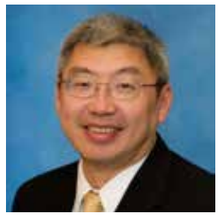

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Member Society News

THE BELGIAN SOCIETY FOR SURGERY OF THE HAND

The Belgian Society for Surgery of the Hand introduced the Belgian Hand Surgery Certificate (BHSC) in October 2018. This Continuing Educational Program (PVG) with a Certificate, is an inter-university training program supported by all seven Belgian Universities. The aim is to standardize the competency in surgery of the hand and peripheral nerves.

The BHSC course runs over two years, consists of 4 modules per year, each module run over 2 days (Friday and Saturday, 8 hours per day). The program entails a mix of theory, case discussion and cadaveric training. At least 80% attendance is obligatory.

The modules are organized in turn by the universities and the teachers are from the participating universities to ensure an optimal standard of training.

The training program is open to all Orthopaedic , General and Plastic Surgeons , as well as residents in their last two years of training from Europe and beyond.

The standard of the program is basic and can prepare them for the European Diploma in Hand Surgery Examination after the required fellowship training. Admission to the program is subject to review by the BHSC Steering Committee and the universities internal regulations.

After the 2 year program, two oral exams are conducted by two inter-university panels, each having two examiners, at least one of them who has to have a PhD. The student may choose to have the examination conducted in Dutch, French or English.

The result of the exam is simply a pass or fail. A pass earns the candidate a Certificate. A student who fails, may request a performance report. One re-exam may be attempted within 3months.

Feedback by students for quality improvement is done on the topics, sessions and speakers after each session.

The first cycle runs from 2018-2020. More information can be had from : https://www.bhsc.be/

ASSOCIATION OF CHINESE-SPEAKING HAND SURGEONS UNITED

The annual event, The Jixia Hand Surgery Forum, was held in Tianjin, June 13-16, 2019, co-organised by Tianjin Hospital, together with Nantong University, Shandong Provincial Hospital and Beijing Jishuitan Hospital. The Forum was paired with Pre-IFSSH meeting organised by the Association of Chinese-speaking Hand Surgeons United in Tianjin.

The Forum and pre-IFSSH meeting were attended by more than 500 hand surgeons from mainland China and other countries. The entire events were live broadcasted through Wechat all over China, with over 2,000 hand surgeons online watching nationwide. The yearly forum is featured with systematic presentations and lively debates. In this year's event, the debates included fingertip repair, position of hand immobilisation, in situ cubital tunnel release versus anterior transposition of the ulnar nerve, treatment of Kienbock's disease, nerve transfer, nerve super-charging procedures, selections of free flaps for soft tissue defects, and treatment of congenital anomalies of the hand. International attendees presented techniques on free flap transfers, biomechanics of distal radius fractures, and diagnosis of median nerve compression in the forearm. Night sessions featured lectures from Drs. Don Lalonde and Elisabet Hagert on tendon repair and nerve compression of the upper extremities. The night sessions lasted until 10:20 in the evening.

The pre-IFSSH meeting focused on wide-awake surgery in China, where wide-awake surgery is very popular. In Tianjin Hospital, the host of the meeting, more than 20,000 patients underwent wide-awake surgery in the past 3 years. This is perhaps the largest case series in a single unit in the past 3 years. Other hospitals in China, including Nantong University, Shandong Provincial Hospital, Qilu Hospital of Shandong University, and Jiangyin People's Hospital, popularly use this approach. The presentations from outside mainland China included a series of talks from Drs. Don Lalonde, Elisabet Hagert, Gregory Bain, and Sang-Hyun Woo on their uses of this approach.

Drs. Carlos Henrique Fernandes and Shanshan Jing introduced hand surgery in Brazil and UK.
Free papers on treatment of distal radial fracture, wrist arthroscopy, digital sensate flap transfers, finger joint replacement, and hand fractures.
The pre-meeting concluded with a night boat tour in Haihe, with astonishing views of the Tianjin skyline and historic area along the Haihe.

The Forum will be held next year in Beijing, and will be organised by Beijing Jishuitan Hospital in April, 2020.

The photos are from the Forum and pre-IFSSH

ECUADORIAN HAND SURGERY SOCIETY (ECUMANO)

A brief history
Hand surgery in Ecuador has an interesting beginning. In 1964 the first hand transplant in the world was done in the city of Guayaquil, performed by Dr Roberto Gilbert Elizalde and his surgical team. This caused international interest. A team from Boston, USA visited to study the case.

Despite this fact and for some other reasons, the development of hand surgery as a specialty in Ecuador was very slow. It was not until 5 years ago that a group of specialists in hand surgery saw the need to have an entity which would unite the Ecuadorian Hand Surgeons. Before then, it was only the Ecuadorian Orthopedics and Traumatology Society which had chapter dedicated to hand pathology.

During the 2016 IFSSH Congress in Buenos Aires, this steering group met in a restaurant and signed a document to establish the Ecuadorian Society for Surgery of the Hand (ECUMANO). This document is seen as the charter of ECUMANO (Act of Foundation). Legal status of the Society took some time and was officially recognized on 17 May 2019 by the Ecuadorian Public Health Ministry (Ministerial Agreement 360-2019).

Since ECUMANOS has been meeting and been in existence actively promoting hand surgery for the last 3 years in Ecuador, the current IFSSH President Marc Garcia-Elias encouraged our Society to join the IFSSH as a full Member Society. The Ecuadorian Society was voted the 60th Member of the IFSSH in Berlin in June 2019.

During the short existence of our Society, we have organized several national courses, Webinars with foreign colleagues from Member Societies, and have participated in international congresses, such as the Bi-national Colombo-Venezuelan Congress and the 2018 FESSH Congress in Copenhagen.

Currently ECUMANO has 5 founding members, 10 associate members and 4 aspiring members. We expect a keen growth of membership now that our Society has become a Member of the international hand surgery family. This will certainly boost our effort to improve the general standard of hand surgery in our country.

BRAZILIAN SOCIETY FOR SURGERY OF THE HAND (SBCM)

1. The 39th Brazilian Congress for Surgery of the Hand

The 39th Brazilian Congress for Surgery of the Hand will be held from 1-3 August in the city of Gramado, in the southern region of Brazil. This year there will be a large number of international speakers: Francisco Soldado (Spain), James Calandruccio (USA), Jeffrey Greenberg (USA), Jorge Clifton (Mexico), Michael Housman (USA), and Ronaldo Carneiro, a Brazilian from Naples – USA, who will be our Honored Guest.

The invited national Member Society will be Israel. With an impressive delegation, the Israeli colleagues will share their experiences on various ways to treat injuries.

This year's program focuses on new treatments and debates. We want participants to share their ideas, clarify doubts, and share stories. "The lectures are great tools for getting to know something new, but the discussions are the ones to strengthen learning," says SBCM's Vice President and the 39th CBCM's President Milton Pignataro.

For more information, refer to the site: www.mao2019.com.br.

2. The Brazilian Society for Surgery of the Hand actively participated in the 14th IFSSH Congress in Berlin, June 2019

From 17-21 June, during the 14th IFSSH Congress in Berlin (International Federation of Societies for Surgery of the Hand), about 120 members of the Brazilian Society for Surgery of the Hand actively participated in the scientific program. It was one of the largest delegations among the 92 participating countries.

The Brazilian Society (SBCM) presented Rio de Janeiro to host the 2025 IFSSH Congress and for that purpose it developed certain actions such as the presentation of a well-structured bidding process, with information about the city of Rio and the infrastructure available for the events, as well as a book about the 60 years of existence of the Brazilian Society for Surgery of the Hand which is celebrated this year. This material was sent to all the delegates of the IFSSH Member Societies beforehand.

Unfortunately, Brazil was not the country chosen, but the feeling remains: "We are sure that we have done our best for the Society. We are also sure that a lot still has to be done, especially by the new generation of hand surgeons in Brazil. "To present Brazil and SBCM to international colleagues was a unique experience", says SBCM's President Marcelo Rosa de Rezende.

3. Brazilian surgeons are honored as "Pioneers of Hand Surgery"

Every three years, during the IFSSH Congress, surgeons from all over the world are honored as "Pioneers of Hand Surgery". At the IFSSH Congress in Berlin, the Brazilians Claudio Henrique Barbieri, and Edie Benedito Caetano, were among the other Pioneers honored.

Claudio Henrique Barbieri was in Germany to receive his award while Edie Benedito Caetano could not attend the ceremony and was represented by the SBCM's secretary, Samuel Ribak.

AUSTRIAN SOCIETY FOR SURGERY OF THE HAND

The Annual Congress of the Austrian Society for Surgery of the Hand (OEGH) in co-operation with the Austrian Society for Hand Therapy (OEGHT) took place in the west of Austria in Montforthaus, Feldkirch from 1-2 March 2019. Dr. Christoph Mittler hosted 153 participants and organised an interesting programme under the topic "Hand - Injuries and tendon diseases". During these Congresses the Board and other Committee Meetings take place.

The Society's work includes several working-groups and various committees, amongst others 'Hand Therapy', 'Future of Hand Malformations in Austria' and 'Hand Surgery Specialisation. We are pleased that a "Young Hand Surgeons Forum" was established. The forum has its own Committee and reports to the Board of the Society. This new group presently has 35 members.

We completed the Austrian Register on the use of XIAPEX for Dupuytren's disease. The Register has 788 patients with 814 interventions.The results will be published soon.

We are looking forward to our next Annual Congress which will be held in Murau (Styria) under the leadership of Dr. Walpurga Schiffer. The topic for the event is "Rheumatology & Prosthetics" and will take place from 6-7 March 2020.

Photo 2: 153 participants took part at the annual Congress 2019.

Photo 1: Annual Congress at Montforthaus in Feldkirch.

CHILEAN SOCIETY FOR SURGERY OF THE HAND

Since the last time we published in the IFSSH Ezine many interesting things happened.

Juan Manuel Breyer completed his term as president and Rene Jorquera assumed as new president, Sebastian von Unger as vice-president and Miguel Sanhueza as secretary of the Chilean Hand and Microsurgery Society.
Lorena Parra is still our IFSSH delegate doing a great job.

Last year, another EWAS Wrist Arthroscopy course was completed in Santiago de Chile with international guest participation of Pedro Delgado, Gustavo Mantovani and Martin Caloia.

The Chilean Orthopedic Society (SCHOT) meeting held in Santiago in November 2018 was well attended, and we were pleased to welcome Julie Adams, Alex Shin and Alton Barron in Chile. They gave excellent lectures and enjoyed our Chilean hospitality.

The triennial IFSSH Congress in Berlin was an amazing experience. It was a comprehensive meeting with a wide range of topics and many friends. Chile actively participated with lectures, paper presentations and panel discussions. The Chilean surgeon delegation was one of the biggest yet (Photo)

We are now preparing to participate in the South American Congress in Cartagena de Indias in August, then the ASSH meeting and our own meeting in November in Santiago. The invited guests are Andrea Atzei and Bauback Safa.

Chile is the 2020 invited Society to the AAOS meeting in Orlando, Florida.

We are proud of the work we are doing and the visibility that our Society is having around the globe. This is in part thanks to the IFSSH.

Hope to see our Hand Surgery friends again soon.

Images from the IFSSH/ IFSHT Congress in Berlin June 2019









Berlin
Welcome to Berlin
Germany






























14th IFSSH
11th IFSHT
TRIENNIAL
CONGRESS
Berlin
2019











PERIPHERAL NERVE/
BRACHIAL PLEXUS

































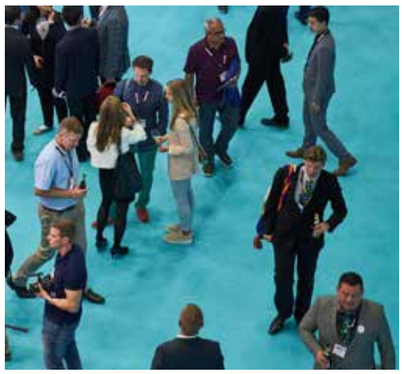




Welcome to Berlin














ifsht
International Federation of Societies for Hand Therapy

www.ifssh.info
To provide global networking and educational opportunities to develop and enhance the practice of hand therapy

UPDATE

www.ifsht.org | info@ifsht.org

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11TH IFSHT TRIENNIAL CONGRESS: BERLIN, GERMANY

The 11th IFSHT and the 14th IFSSH Triennial Congresses June 2019 in Berlin saw **THE BIGGEST GATHERING EVER IN THE WORLD OF HAND THERAPISTS AND HAND SURGEONS.** Of the 4,001 attendees from 92 countries, more than 700 were hand therapists !!!

Anne Wajon, IFSHT President, (at podium) recognizes the German Organizing Committee: L to R are Katja Karasev, Natascha Weihs, Beate Jung, Johanna Ismaier, Christine Popp, and Dominik Simon

The four-day programme was packed with instructional lectures, scientific paper presentations, workshops and more than 150 e-posters. Special thanks to Natascha Weihs & Beate Jung who co-chaired the IFSHT Congress and many thanks to Ms. Jung and Dorit Aaron who co-chaired the scientific committee, and Lisa O'Brien, who chaired the abstract review committee, for developing such an educationally stimulating program.

2019-2022 IFSHT EXECUTIVE

Six therapists have volunteered to lead IFSHT in the coming three years. Contact details for all EXCO members can be found at **www.ifsht.org**.

L to R: Anne Wajon (AU), Past-President; Nicola Goldsmith (UK), President; Peggy Boineau (USA), President-Elect; Maureen Hardy (USA), Secretary General; Susan de Klerk (SA), Information Officer and Stacey Doyon (USA), Treasurer.

CRISTINA ALEGRI INNOVATION AWARD

A blinded IFSHT international evaluation committee chose **Judy Bell-Krotoski** posthumously for her contribution to the development and standardization of the Semmes Weinstein monofilaments for sensory testing. She was chosen from eight nominees.

IFSHT LIFETIME ACHIEVEMENT AWARD

The **NEW** Lifetime Achievement Award has been developed to recognise therapists who have made outstanding contributions to hand therapy internationally. Their contributions will influence many generations to come.

L to R: D Thomas (FR), J-C Rouzaud (FR), C van Velze (SA), R Prosser (AU), M Persson (SE) (rear), V Frampton (UK) L Feehan (CA) (rear), P McKee (CA), A Estrada (CO), S Chinchalkar (CA), J Colditz, (US) and A Wajon (AU), IFSHT President. E Mackin (US) and A Leveridge (UK) were unable to attend to receive their awards.

IFSSH EZINE

The IFSHT contribution to the May 2019 IFSSH EZINE is a valuable resource for hand therapist clinicians: "Improving thumb MCP joint stability with a simple lightweight splint" by Sarah Ewald (CH).

IFSHT is keen to have interesting, clinically relevant articles to contribute to the IFSSH Ezine. Contact **informationofficer@IFSHT.org** to contribute or if you have a suggested

For hand therapy educational events, go to "National/ International Education Events" under "Education" at **www.ifsht.org**.

ASIA PACIFIC WRIST ASSOCIATION

APWA

SEOUL

5th Congress of Asia Pacific Wrist Association (APWA)

November 7~9, 2019

Seoul St. Mary's Hospital,
Seoul, South Korea

Abstract Submission Deadline: July 31, 2019

Abstract Acceptance Announcement: August 31, 2019

Early Bird Registration Deadline: September 30, 2019

Website: http://www.APWA2019.com

Secretariat of APWA 2019
124, Bukbyeonjung-ro, Gimpo-si, Gyeonggi-do, Republic of Korea 10098
Phone : +82-31-987-5963 Fax : +82-31-987-5967
E-mail : gaonpco@gaonpco.com

2019 Hong Kong International Wrist Arthroscopy Workshop and Seminar

2019 年度香港国际腕关节镜工作坊及研讨会

7 December 2019 (Saturday)

International Wrist Symposium & Clinical Workshop on Arthritis

腕关节炎疼痛专题研讨会及临床工作坊

Target Participants 参加对象:
Doctors, Therapists, Nurses and related professionals 医生,治疗师,护士及其他有关专业人士

8 - 9 December 2019 (Sunday - Monday)

Hands-on Wrist Arthroscopy Workshops

腕关节镜操作班

Target Participants 参加对象:
Orthopaedic Surgeons & Hand Surgeons 骨科医生及手外科医生

Course Director 课程主任: PC HO 何百昌


Mark BARATZ
(USA 美国)


Eva-Maria BAUR
(Germany 德国)


Wei-Jen CHEN
(Taiwan 台湾)


Jeff Oscar ECKER
(Australia 澳洲)


Mireia ESPLUGAS
(Spain 西班牙)


Keiji FUJIO
(Japan 日本)


Guillaume HERZBERG
(France 法国)


Young-Keun LEE
(Korea 韩国)


Bo LIU
(China 中国)


Toshiyasu NAKAMURA
(Japan 日本)


Jui-Tien SHIH
(Taiwan台湾)


Xiao-Feng TENG
(China 中国)

Organizer 主办单位:

Orthopaedic Learning Centre, Department of Orthopaedics & Traumatology
The Chinese University of Hong Kong
香港中文大学矫形外科及创伤学进修培训中心

Hong Kong Society for Surgery of the Hand
香港手外科医学会

For Enquiries 如有查询:
Email 电邮: olc-ort@cuhk.edu.hk
Website 网页: www.olc-cuhk.org

Organized By:

FOUNDATION FOR HAND SURGERY
Education, Research and Clinic

Contact
info@foundation-handsurgery.org

To European Societies for Surgery of the Hand

We set up the **Hand Surgery Foundation** dedicated to Education and Research in Hand Surgery.

The Foundation for Hand Surgery is a non-profit European organization, independent, without industrial support or conflict of interest. The status of the foundation based in Geneva can be consulted on the website www.foundation-handsurgery.org.

Its aim is to offer additional training opportunities for hand surgeons at all stages of their professional training, from the early years to the final stages of perfecting their already acquired technical skills.

Education program includes both **junior sessions** for surgeons-in-training and **senior sessions**. The "senior" sessions are intended primarily for surgeons wanting to benefit from the experience of expert surgeons with a reputation on a particular issue. Many invited experts from Europa are part of the education training program.

The sessions are organized in **Geneva** (Swiss Foundation for innovation and training surgery- SFITS- Geneva University Hospital) and at the School of Surgery in the microsurgery laboratory (**Nancy**, Fr).

The program of **the next training modules** over a period of three months, is below.

Applicants participating in the training will be able to register on the dedicated site www.foundation-handsurgery.org.

We hope to see you and share our experiences.

The Foundation does not belong to anyone; its aim is to be there for everyone.

Best regards,

Gregoire Chick, Gilles Dautel, Philippe Bellemère, Bruno Lussiez, Alain Tchurukdichian

Foundation for Hand Surgery
Campus Biotech Innovation Park, Bâtiment F2/F3, Avenue de Sécheron 15, CH-1202 Geneva, Switzerland
Tel: +41 225 45 12 92 - info@foundation-handsurgery.org
www.foundation-handsurgery.org
nonprofit organization

EWAS ISTANBUL, TURKEY
SEPTEMBER 20-21, 2019
5th WRIST ARTHROSCOPY COURSE

http://www.wristarthroscopyturkey.org/

(with International Participation)

UNIVERSITY OF HEALTH SCIENCES
BALTALIMANI BONE DISEASES
TEACHING AND RESEARCH HOSPITAL

CHAIRPERSONS

Prof. Dr. Kahraman OZTURK & Prof. Dr. Tufan KALELI

SCIENTIFIC SECRETARIAT

Prof. Dr. I. Bulent OZCELIK

Asst. Prof. Dr. Ayse SENCAN

3rd 'Overseas Day' Symposium

Effective Teaching across Cultures in Global Surgery

13 September 2019 | 09:00 - 17:00

Location

Royal College of Surgeons of Edinburgh

A one-day symposium for anyone interested in overseas work in developing countries, particularly in the fields of plastic or hand surgery.

Topics for Discussion:

- How to Get Involved in Surgical Work Overseas
- Cultural Factors in Global Surgical Training
  - Expert speaker
  - Local surgeons from across the globe give personal insights
- Making use of Technology in Global Surgical Teaching
- Designing Surgical Curriculum for the Local Environment

Intended Audience:

- Consultant Volunteers
- Therapists
- Trainees

Places are limited and are secured by giving your credit card details to the BSSH office - no money will be taken but non-attendance will cost £50.
Please complete and return the form overleaf if you wish to attend

Registration Form

Name	
Email Address	
Contact Address	
BSSH Member or Associate?	

Attendance of the event is free of charge; however, we request credit card details from all delegates to secure a place at the event.
Non-attendees who do not cancel their places prior to the event will be charged a non-attendance fee of £50. This amount will be charged to your credit card after the event.

Card Details:

Mastercard / Visa / Visa Electron / Maestro (Please circle)

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Validation Code: ☐☐☐

Expiry Date: ☐☐ ☐☐

Billing address if different from above	

I understand the above conditions of registration

Signature	Date

To reserve your place on the course, please complete and return this form to: BSSH, Royal College of Surgeons, 35-43 Lincoln's Inn Fields, London WC2A 3PE
Or email to **secretariat@bssh.ac.uk**

12APFSSH/8APFSHT

12th Asian Pacific Federation of Societies for Surgery of the Hand &
the 8th Asian Pacific Federation of Societies of Hand Therapists Triennial Meeting

11-14 March 2020 | Melbourne Convention and Exhibition Centre

apfssh2020.org

We look forward to seeing you in Melbourne from the 11th - 14th March 2020, to learn, be inspired, network with colleagues and enjoy everything Melbourne has to offer.

WEB apfssh2020.org • CONTACT US info@apfssh2020.org

New Zealand Society for Surgery of the Hand

12APFSSH/8APFSHT

11-14 March 2020 I Melbourne Australia

Hand Surgery and the Digital Revolution

INTERNATIONAL FEDERATION OF SOCIETIES FOR SURGERY OF THE HAND