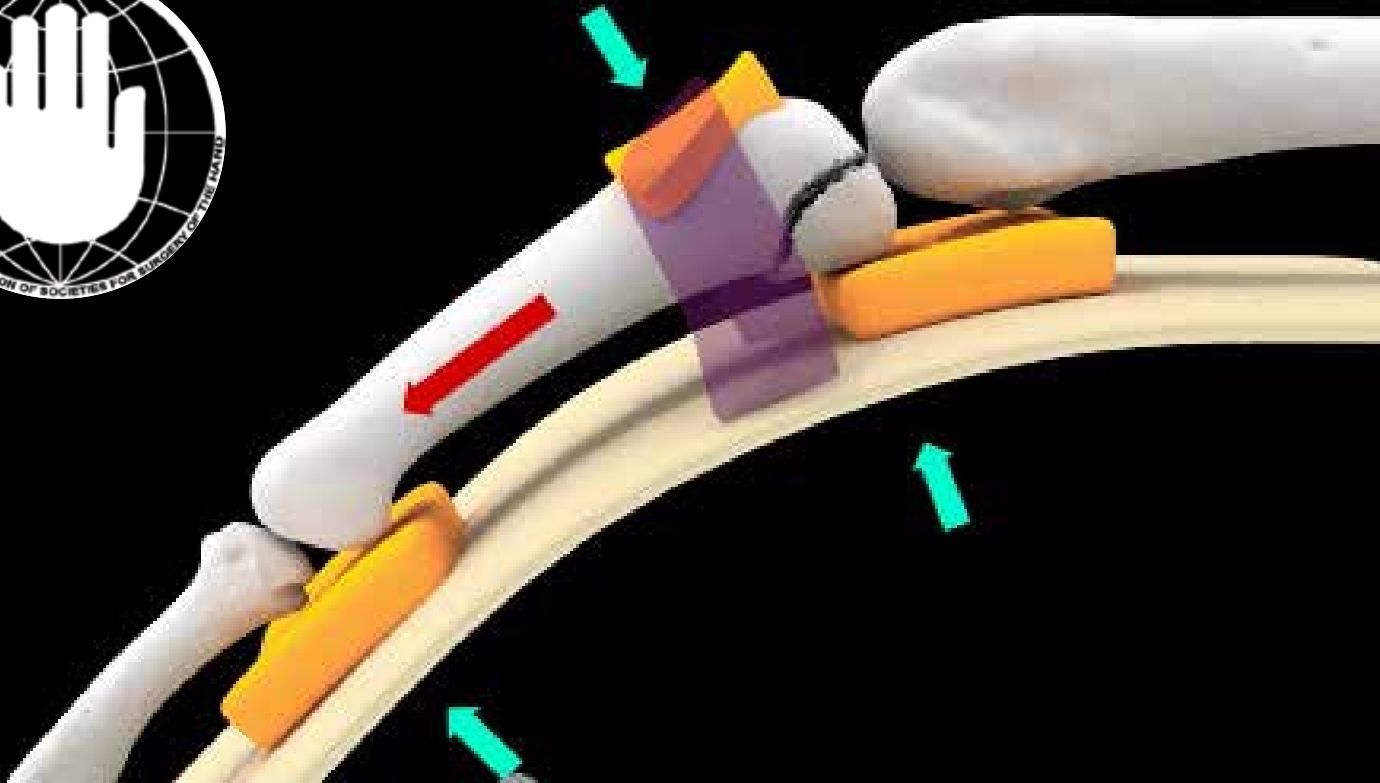


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HAND THERAPY



Early Active Vector Adjustable Skin Traction for Phalangeal Fractures

THE NON-OPERATIVE MANAGEMENT OF
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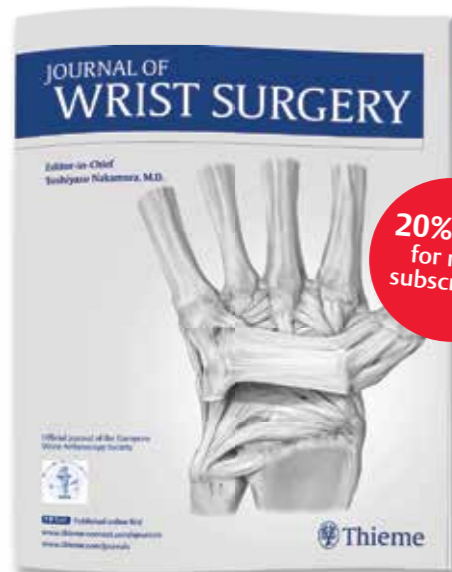
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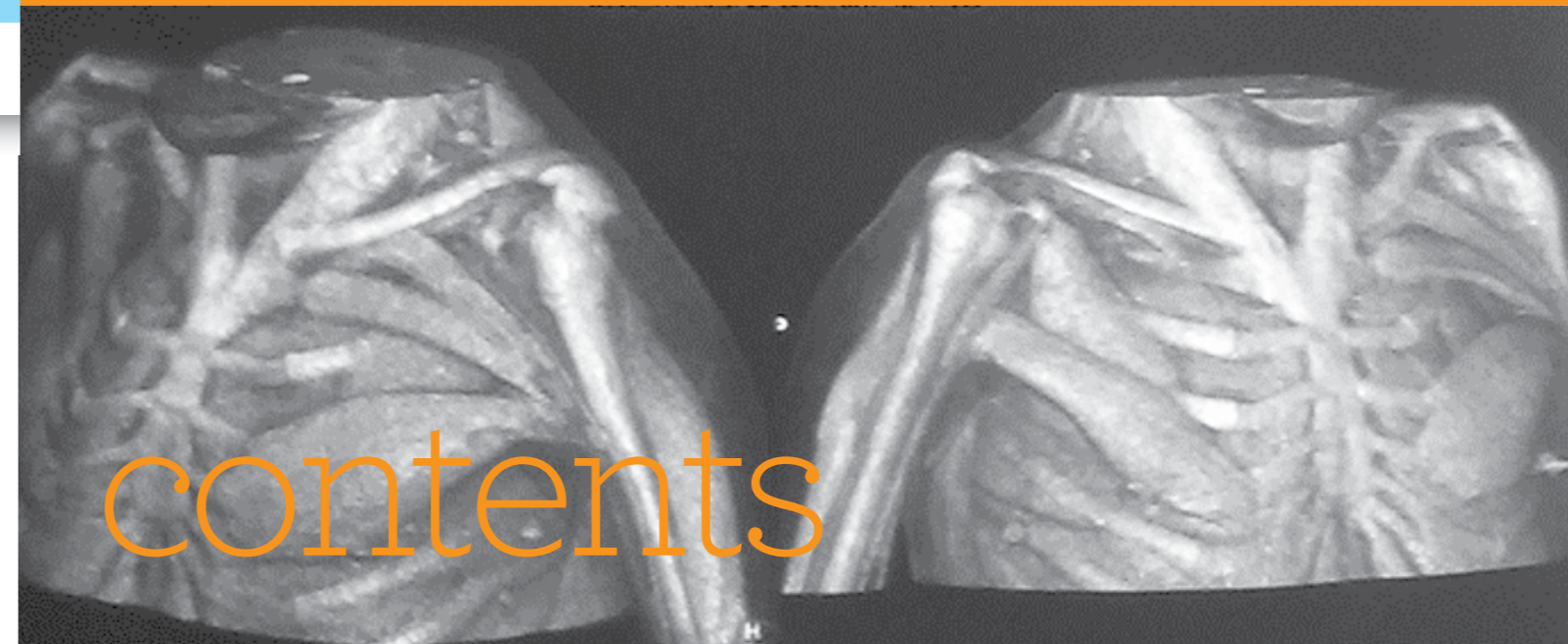
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Invitation

The "IFSSH Ezine" is the official mouthpiece of the International Federation of Societies for Surgery of the Hand.

It exists to keep Member Societies and their Members in contact and share useful information and happenings around the world, hence our logo: "FOR THE MEMBERS, BY THE MEMBERS"

It is with great appreciation that we acknowledge the many contributions from individual Members as well as the Scientific Committees over the years. All previous Ezine editions can be accessed from the IFSSH website: www.ifssh.info

Every Member is reminded that the Ezine is "your" magazine, and therefore letters, opinions and contributions are most welcome.

This November issue features an unique sculpture of a candle holder. You are invited to share interesting, informative or striking photos of items or incidences related to the Hand.

Back to basics: the Hand Therapy chapter compliments the Research Round-up by Grey Giddens on the conservative management of hand fractures.

The IFSSH has been very active in financial sponsorships in the last few years: some interesting reports acknowledge this important function of the Federation.

Please note the Berlin IFSSH-IFSHT Congress dates have been changed to 17 - 21 June 2017.

The Editorial Team wishes all our readers a meaningful Festive Season and pleasant holidays.

Enjoy the reading.

Ulrich Mennen
Editor: IFSSH Ezine
www.ulrichmennen.co.za



IFSSH DISCLAIMER:

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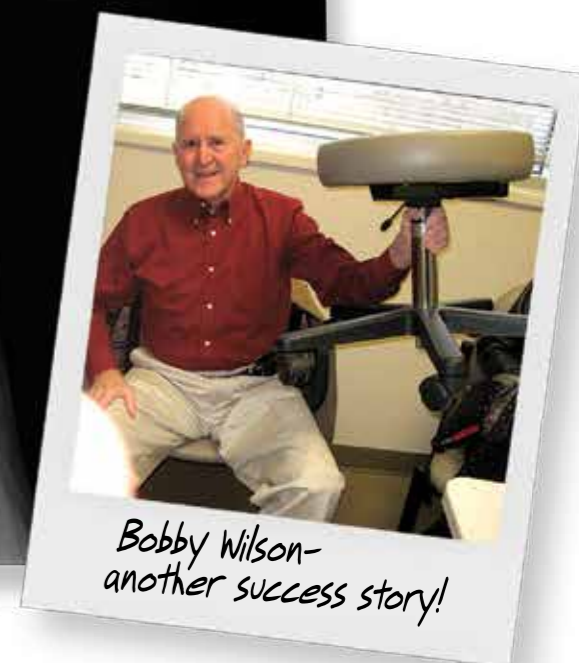
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IFSSH Newsletter

The Executive Committee of the International Federation of Societies of Surgery of the Hand and the IFSSH Delegates met in San Francisco on Wednesday, September 6 and Thursday, September 7, 2017 during the annual meeting of the American Society for Surgery of the Hand. The ASSH very graciously provided the meeting space for the Executive Committee and Delegates meetings.

This was the first Delegates meeting since the 13th Triennial meeting in Buenos Aires. Dr. Eduardo Zancolli III, the President of the 13th IFSSH Congress provided a written report containing the highlights of the Buenos Aires Congress. Over 1700 participants attended the meeting. The IFSSH program included 40 symposia and round tables with more than 200 speakers, 266 free papers, 4 debates, 4 problem cases sessions and 330 electronic posters. The Buenos Aires Congress was a grand success not only academically but also socially and financially. The IFSSH is indebted to Dr. Zancolli and the Argentinian Association for Surgery of the Hand (Asociacion Argentina de Cirurgia de la Mano) for organizing a phenomenal meeting.

Speaking of triennial meetings, Dr. Karl-Josef-Prommersberger, the German Society of Hand Surgery (Deutsche Gesellschaft für Handchirurgie DGH) IFSSH Delegate provided on behalf of Dr. Jörg van Schoonhoven the chairman of the DGH organizing committee, a preview of the 14th IFSSH Congress and the 11th Triennial Congress of the International Federation of Societies for Hand Therapy to be held in Berlin on June 17 -21, 2019. The new and exciting CityCube Berlin has been selected as the meeting venue. The German Society for Hand Therapy (Deutsche Arbeitsgemeinschaft für Handtherapie (DAHTH)) will host the IFSHT Congress. The Federation of European Societies for Surgery of the Hand (FESSH) will also participate in the IFSSH Congress and conduct its committee meetings and the FESSH examination. The Berlin Congresses will undoubtedly be spectacular events with excellent educational and social programs for hand surgeons and therapists alike. Please be sure to place this on your calendar!

The British Society for Surgery of the Hand is very excited about hosting the 15th Triennial Congress of the IFSSH to be held in London in 2022. This Congress will also include the IFSHT and the FESSH. The British society is very enthusiastic about the Congress and will spare no effort to make it a great success. The details of the meeting are not yet available. Stay tuned!

It is a pleasure to announce that the IFSSH family is growing. Applications for IFSSH membership from the Association of Chinese-speaking Hand Surgeons United and the Guatemalan Society of Hand Surgery were reviewed and accepted by the Executive Committee and Delegates. The IFSSH is now a federation of 59 societies from 57 nations! Congratulations and welcome to our newest member societies!



The IFSSH is dedicated to educating hand surgeons around the world and particularly surgeons in less affluent nations. The Federation is fortunate in that it has sufficient reserves to support educational endeavors around the world. The IFSSH Committee for Educational Support (CES) is anxious to receive applications for financial support of hand surgery education from the IFSSH member hand societies. Such educational endeavors can include regional courses, visiting professorships, outreach programs including education and medical missions as well as grants for attendance at the IFSSH Triennial meetings. It is our duty as a federation and as individual societies to do what we can to improve the education of hand surgeons in less fortunate areas of the world and by extension the care of patients in those regions. The Executive Committee of the IFSSH would ask our member societies to accept this responsibility and organize regional courses outreach programs and other educational programs. The IFSSH stands ready to support your educational efforts. Please go to the IFSSH website for information regarding the grant application process. And if you have any questions please contact us at administration@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:

XIVth IFSSH – XIth IFSHT Congress – Berlin, Germany 17-21 June 2019

www.ifssh-ifsht2019.com

XVth IFSSH – XIIth IFSHT Congress – London, United Kingdom

2022 (Dates to be confirmed)



Daniel J. Nagle MD

Secretary General IFSSH

James Harold Dobyys

1924- 2011



Jim Dobyys was born in Hazard, Kentucky, USA, on Halloween (31 October) of 1924 and continued to view the annual extravagances of that date as a personal fief. He matured in a mountain valley in eastern Kentucky, emerged to attend the state University of

Kentucky and almost immediately found it expedient to volunteer for service in World War II. That service eventually and fortuitously resulted in an appointment to the Indiana University Medical School from which he graduated in 1948. A certain sense of obligation and a preferential pay scale led to a return to military service, an introduction to the principal prize of his life, his wife Betty, and a 20 plus year career in the US Army, and then the US Air Force. During this time, Dr. Dobyys developed a special interest in surgery of the hand and was able to focus on that interest, first as the third hand fellow in the Robert E. Carroll New York Orthopaedic Fellowship Program and finally as the director of the first military hand service in San Antonio, Texas, USA, after the closure of the special centres of World War II.

Association during that early, exciting period with Drs. Carroll, Riordan and Flatt, followed shortly by an intercity exchange with Drs. Omer and Rowland, led to those special niches of hand surgery in which Dobyys has been involved ever since, i.e. congenital hand deformities, wrist trauma and other problems, occupational/avocational injuries of the upper limb and pain dysfunction problems.

A midcareer trial at teaching was sufficiently attractive, that Dobyys has never left the academic aspects of hand surgery, continuing such during the last ten years of his military career, a twenty year career at the Mayo Clinic and another eight years in association with Dr. David P Green's office and the University of Texas Health Science Centre in San Antonio, Texas.

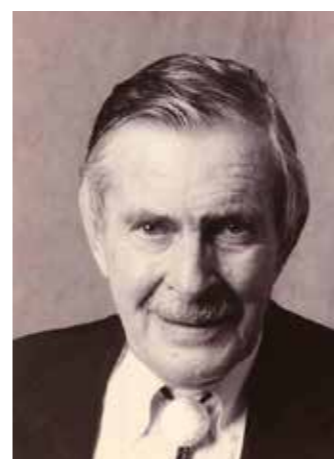
Along the way, Jim Dobyys was involved with four residency and two fellowship programs. He has published some 200 papers (many co-authored with Ronald L. Linscheid, MD) and many textbook segments. He was the Founding Editor of the "Year Book of Hand Surgery" as well as the Hand Section Editor of the "Year Book of Orthopaedic Surgery". Dobyys was president of several professional societies including the American Society for Surgery of the Hand and was Professor of Orthopaedic Surgery at the Mayo Clinic and the University of Texas.

In retirement, Dr. Dobyys continued to agitate the careers of his many students both personally and on the Internet, being viewed by many as an information broker. He passed away on 18 July 2011.

James H Dobyys was honoured as "Pioneer of Hand Surgery" by the International Federation of Societies for Surgery of the Hand at its Seventh International Congress in 1998 in Vancouver, B.C., Canada.

Mack L. Clayton

1921- 2007



Mack Clayton was born in Round Mountain, Alabama, USA, on November 25, 1921 and grew up in Tucson, Arizona, USA. He graduated from the University of Arizona in 1942 and received his MD from Columbia University in 1945. After his internship at the Peter Bent Brigham Hospital and the US Army (1946-47),

he trained in orthopaedic surgery in Boston at Cushing VA Hospital and Boston Children's Hospital (1948-51). He served on the staff of Massachusetts General Hospital with Edwin Cave and Carter Rowe, and was the first orthopaedic surgeon assigned to their Hand Clinic. He moved to Denver in 1952 and founded a private practice, later known as the Denver Orthopaedic Clinic. He was certified by the American Board of Orthopaedic Surgery in 1954.

Clayton's interest in rheumatoid arthritis led to his association with Charley Smyth, Professor of Medicine and Chair of Rheumatology at the University of Colorado Health Sciences Centre. Together they began a comprehensive combined orthopaedic-arthritis clinic which met weekly for 20 years, one of the first such programs in the USA. Dr. Clayton has published over 100 articles, about half on upper extremity arthritis surgery, and a number on original subjects. His first presentation to the ASSH (1967) was: Surgery of the Rheumatoid Thumb, the first published paper on the subject. In 1965, he presented Surgery of the Rheumatoid Wrist describing the first intramedullary technique for wrist fusion in the neutral position. In 1974, with co-author Don Ferlic, he described a tendon transfer

to correct radial deviation of the wrist. In 1992, he edited with Prof. Smyth "Surgery for Rheumatoid Arthritis – A Comprehensive Team Approach", a book representing 38 years of experience.

Mack Clayton was member of over 20 Societies, including honorary memberships of the Norwegian and European Rheumatoid Arthritis Surgical Societies, and the Caribbean and Venezuelan Societies for Surgery of the Hand. He has been active in the Arthritis Foundation, and was Chairman of the Arthritis Committee for the AAOS (1965-71), Vice-President of the American Rheumatism Association (1974), President of the Clinical Orthopaedic Society (1977), and member of the Council of the ASSH (1985-87). He was Clinical Professor of Orthopaedic Surgery and Clinical Professor of Surgery (Hand) at the University of Colorado Medical School. He has trained over 30 fellows in arthritis surgery, has lectured in over 20 countries and was Visiting Professor at 16 institutions. After retiring from private practice in 1990, he was involved part-time at the VA Medical Centre, part of the UCHSC teaching program.

Dr. Clayton was physician for the Denver Broncos football team (1969-72) and for the US Ski Team (1971). He and his wife Sally were Elders in the Presbyterian Church and have served as Volunteers in Mission in Ethiopia, Egypt and Thailand. He was active in skiing, golf, tennis, fishing and hunting.

Mack L Clayton passed away on 26 February 2007.

At the Seventh International Congress of the International Federation of Societies for Surgery of the Hand held in Vancouver, B.C. Canada in 1998, Mack Clayton was honoured with the title: "Pioneer of Hand Surgery"

Early Active Vector Adjustable Skin Traction (EAVAST) for Phalangeal Fractures

Phalangeal fractures, especially those involving the proximal interphalangeal joint can be complex to treat and may involve disruption of the static and dynamic bone and soft tissue apparatus.¹ Various surgical options are available including Kirschner wires, screw fixation, hemi-hamate replacement, Suzuki frames and volar plate arthroplasty. However, complications such as neuropathic pain, post-operative stiffness, pin loosening and infection are often reported.²

The use of ligamentotaxis, whether via skeletal or skin traction, has been documented in the literature stemming from initial work pioneered by Schenk³ and the original Southampton technique described by Fitzgerald and Khan⁴. These techniques have been modified over time, and utilise tensioning the soft tissue envelope to reduce fracture fragments, prevent peri-articular adhesions, and allow early motion as shown in Figure 1. Figure 2 demonstrates the use of bolsters and straps for fracture realignment.

The Early Active Vector Adjustable Skin Traction (EAVAST) method was developed in Nepean Hospital, Sydney, Australia and initial results of a retrospective study were published in the journal *Hand*⁵ and presented at the International Federation of Societies for Surgery of the Hand (IFSSH) Conference in Argentina in 2016.

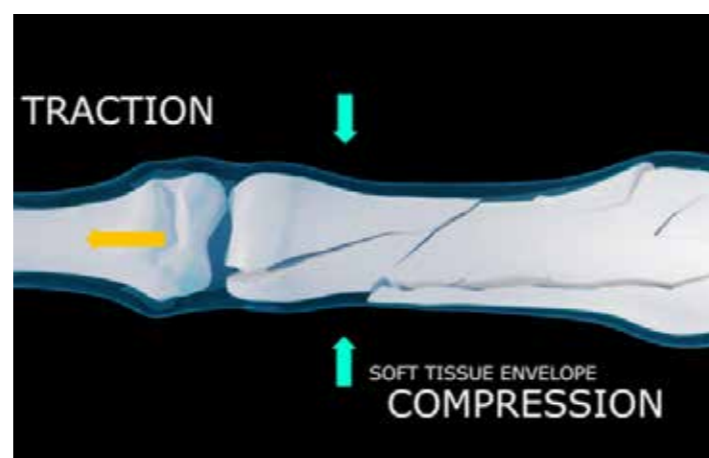


Figure 1. Ligamentotaxis. Distraction tightens the soft tissue envelope & realigns fracture

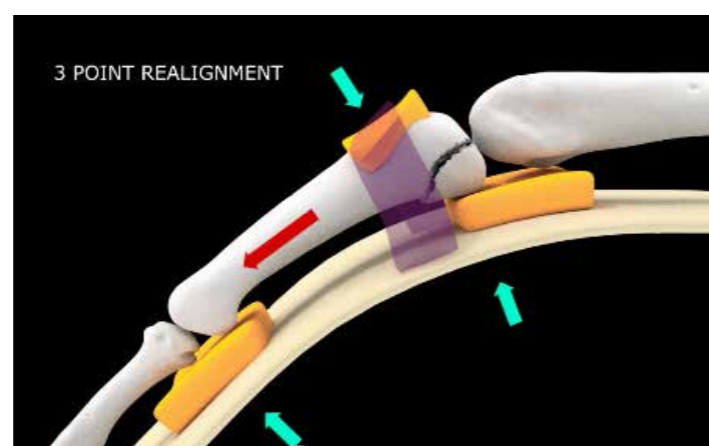


Figure 2. Ligamentotaxis. Distraction tightens the soft tissue envelope & realigns fracture

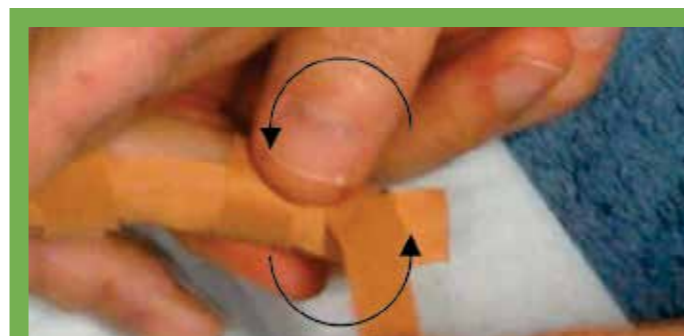
The technique involves the following components:

1. Application of an adhesive tape to the finger both in longitudinal and transverse lines just distal to the site of fracture. An overhang of 1cm is made at the distal end of the finger. A skin prep or adhesive spray can be applied beforehand if required to increase contact. See step 1.



Step 1. Initial taping

2. It is useful to reinforce the tape over the nail in a diamond pattern. This reduced the risk of tape sliding or loosening. See step 2.



Step 2. Over nail tape reinforcement

3. A hole-punch is used to make a hole in the overhang following which an elastic thread can be moved through the hole in the tape to provide a dynamic traction component. See step 3.



Step 3. Elastic threading

4. A soft vinyl plastic tube (5mm Pope tube from garden irrigation supplier) is then inserted over the elastic. The purpose of the tube is to act as a simple tension gauge or 'guide tube', allowing for measurement of force during exercises Step 4.



Step 4. Plastic guide tube added.

5. Tension can be measured and marked on the elastic at the edge of the plastic tube. Forces applied can be from 50 to 500grams. See step 5. The splint can then be fabricated and the elastic pulled over the end of the splint. It is useful to cut a "v" at the distal end of the splint for the elastic to sit in and then pull the elastic to required tension as measured with a tension gauge. A second mark can then be made on the elastic when it reaches the required tension at the distal edge of the splint. All elastic force required for the finger will be from the rigid tapes hole-punch anchor to the distal edge of the splint. It is best however not to have tension slack from the distal edge of splint to the anchor point on the volar aspect of the splint.



Step 5. Tension gauge and marking of elastic at end of guide tube.

6. Splints can be hand based. A hook can be applied to the volar aspect of the splint to secure the elastic, and a mark made on the edge of the splint to maintain a determined traction force. See Figures 3 and 4.



Figure 3. Hand based traction splint for thumb.



Figure 4. Hand based traction splint for fingers with luxafoam bolster block.

7. The patient can remove the splint yet maintain the traction force (step 6) to actively move with guidance towards the scaphoid tubercle (step 7). It is best to move all the fingers to encourage FDP activity. Motion can also be applied passively if required. Repetitions are usually 10 motions, five times a day. The splint is replaced after exercises, ensuring skin condition is maintained.



Step 6. Patient maintains tension at mark.



Step 7. Active movement under traction to scaphoid tubercle.

8. Application of blocks using Luxafoam, neoprene straps and adjustment of the angle of the splint to assist fracture reduction. The bolsters and straps can provide leverage points to allow force to be applied via either translation or through altering the angle of the traction. Figure 4 shows the use of a three point design to assist sagittal translation of the distal fragment and assist realignment. Bolster arrangements can be used to adjust for changes in transverse and coronal axes.

Splint duration.

Our protocol indicates that 3.5 weeks of traction is usually required. However, there are cases where traction is ceased at 2 weeks, and other cases where it is applied for longer periods, depending on fracture healing and alignment. To prevent PIPJ flexion contracture and dorsal subluxation a dorsal extension (blocking) splint is often required either with or after traction.

Skin care.

The splint should be covered in a plastic sealed bag for showering to prevent the tape getting wet and skin maceration. Removal of the tape once to twice a week is required for hygiene. This necessitates removal of traction for a brief period, and the patient may wash the hand under water. In over 100 cases I have not seen a wound develop under the tape. Care should be take in the early stages of fracture healing not to move the fractured finger when the traction is off for these brief periods.

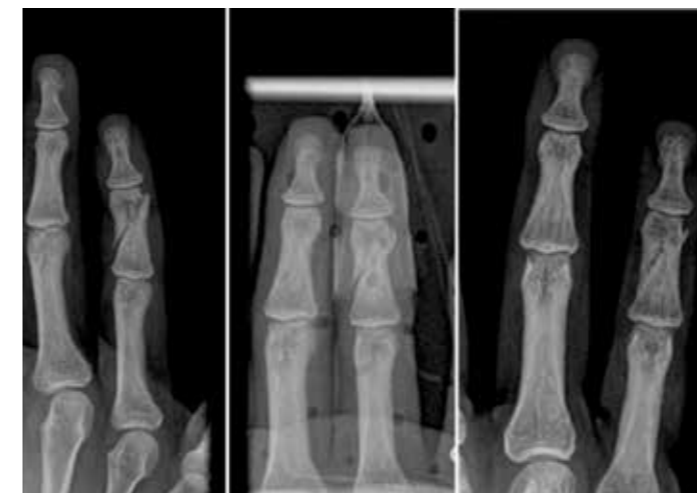
A case series of 54 finger phalanges traction cases treated with EAVAST demonstrated mean TAM of 227.50; excellent outcomes in 37 case s, good in 14 cases and poor outcomes in 3 cases, under Belsky's criteria. Grip strength averaged 32.3kg and was 99.3% of the unaffected limb.⁵ Mild malrotation was observed in two cases, in another case where surgery was combined with the traction scar adhesion were observed but these did not require surgical intervention.

The following pre- and post-traction radiographs show the potential for the EAVAST technique to provide good radiological outcomes.



Volar apex extra-articular transverse shaft fracture

Intra-articular PIPJ fractures with dorsal subluxation



Extra-articular oblique shaft fracture

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About the author:



Jason Fairclough is a Physiotherapist and Certified Hand Therapist, and is the Practice Principal of Hills Family Physio in Sydney, Australia. His current research interests are in the areas of traction methods for management of fractures; competency and education for hand specialisation; and the efficacy

of electrotherapy agents and biometric devices. He is contactable at info@hillsfamilyphyio.com.au. Updates on the skin traction method will be available at hault.net.au and hillsfamilyphysio.com.au. A training video is in being developed to assist practitioners with the technique.

Reports & Updates

ISRAELI SOCIETY FOR SURGERY OF THE HAND (ISSH)

The Israeli-German Hand Surgery Meeting was held in May 2017 in Jerusalem, Israel. A delegation of 15 leading hand surgeons from Germany included Prof. Max Haerle, Secretary General of FESSH, Prof. Nicola Borisch, President of the German Hand Society (DGH) and Prof. Riccardo Guinta. The meeting was coordinated by Prof. Guinta and the chairman of the Israeli Society for Surgery of the Hand (ISSH), Dr. Shai Luria.

The goal of the meeting was to discuss specific topics; war injuries and limb mutilation, treatment of complex fractures and new technologies. Dr. Sorin Lordache (ISSH) described the Israeli care of Syrian war refugees. In a round table we discussed implementation of new technologies; Prof. Martin Richter (DGH) described the use of Xiapex in Germany, Prof. Eva Maria Baur (DGH) described the application of the first feeling prosthesis, Dr. Frederik Verstreken from Belgium talked about patient specific hand surgery and Dr. Uri Farkash (ISSH) presented the experience of implementing wide awake surgery in Israel.



From left to right. Dr. Shai Luria, Dr. Nicola Borisch, Prof. Riccardo Guinta



From left to right. Prof Joel Engel, Prof Iri Liebergall, Dr. Dan Hutt and Prof. Max Haerle.



The conference guests

A special debate (round table) was held regarding ways to promote hand surgery, through public relations, international cooperation and education. The head of the Israeli Orthopedic Society, Prof. Iri Liebergall, remarked on his view of cooperation between hand surgeons and the orthopedic community. Prof. Antal Renner described the role of DGH in the development of hand surgery in Hungary, an outstanding model of continuous international cooperation.

A concurrent workshop on Manual Edema Mobilization Technique was held by the hand rehabilitation group of ISSH, hosted by Canadian therapist, Vivian Dim. The workshop included both lectures and hands-on training in this novel technique.

The social program included an excursion to the old city of Jerusalem and a day trip to the Dead Sea and Masada, where the German guests discovered that floating on water is possible! International cooperation is a goal of the Israeli Society for Surgery of the Hand. Participating in FESSH and IFSSH activities as well as cooperation with various national societies will make the Israeli Society and its members stronger and raise the level of our patient care.

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

The APFSSH member countries have been working efficiently and in harmony in the areas of teaching, publications (Journal of Hand Surgery Asian Pacific Volume), research, conferences, as well as charity medical service in the last 10 years.

Some unique developments around the Asian and Pacific regions have gained attention and recognition around the world which include brachial plexus injury treatment, microsurgery, wrist arthroscopy, sport injury, management of mangled upper extremity, and basic research.

APFSSH meetings have been successfully hosted by respectful hand surgeons in Hong Kong (2008), Taiwan (Kaohsiung, 2009), Indonesia (Bali, 2012), and Malaysia (Kuala Lumpur, 2014).



From left to right. Prof. GH Baek, Prof. M Beppu, Prof. YK Tu, and Prof. R Sabapathy

The 11th congress of the APFSSH in conjunction with the 7th congress of the Asian Pacific Federation of Societies for Hand Therapy (APFSHT) will be held November 7th -10th, 2017, in Cebu city, Philippines. This APFSSH meeting will be one of the most important and of the highest academic standard for hand conferences in the Asian Pacific region.

The aims of this conference are to offer ideal opportunities for hand surgeons, hand therapists, as well as researchers and other physicians who are interested in the field of hand surgery to present their ideas, clinical results, techniques, experiences and knowledge. The scientific program includes interesting hand topics, international guest speakers, special lectures and symposia.

The highlight of the meeting will be the Tajima Lecture to be presented by Professor Akio Minami. The organizing committee has put a lot of effort into the scientific program, the venue arrangement, invitation of speakers, as well as the social activities. Cebu city is one of the best places for visitors in Philippines, which is full of sunshine, hospitality, smiles and a beautiful ocean.

This will be a congress with lots of joy, friendship, and knowledge for our hand surgeons and hand therapists. Based on our previous wonderful experiences, I am quite sure that we will have a successful APFSSH meeting in Cebu city this November.

The presidents of the 9th, 10th and 11th APFSSH are M. Beppu (Japan), YK. Tu (Taiwan), and GH. Baek (Korea), respectively. The secretary general of the 10th (currently) APFSSH is R. Sabapathy (India).

Yuan-Kun Tu, MD, PhD, FICS

President: Asian Pacific Federation of Societies for Surgery of the Hand

Professor & Superintendent: E-DA Hospital / I-Shou University. Taiwan



IFSHT REPORT TO IFSSH, JUNE 2017

Anne Wajon (Australia), IFSHT President 2016-2019
president@IFSHT.org

Presented June 21, 2017, EFSSH Budapest

IFSHT TRIENNIAL MEETINGS

10th IFSHT Triennial Congress / 13th IFSSH Triennial Congress, October 24-28, 2016, Buenos Aires, Argentina

- **Program:** Post conference feedback provided confirmation from delegates that they learned practical skills that should improve practice.
- **Silent Auction:** 301 donated items were presented over 17 tables, and managed by 24 volunteers. This highly successful event collected \$US7255 toward

the IFSHT travel grant fund.

- **New IFSHT Executive Committee appointed:** Nicola Goldsmith (UK), President Elect; Anne Wajon (Australia), President; Sarah Ewald (Switzerland), Past President; Cecilia Li (Hong Kong), Information Officer; Peggy Boineau (USA), Treasurer; Maureen Hardy (USA), Secretary General 11th IFSHT Triennial Congress / 14th IFSSH Triennial Congress, 2019 Berlin, Germany
- **Scientific Program Co-Chairs:** Dorit Aaron (USA) and Beate Jung (Germany)
- **Silent Auction Committee:** Chair is Sabina Haas
- **Convention Management:** Intercongress – I am planning to meet them tomorrow to discuss any identified issues.

IFSHT MEMBERSHIP

- **Full members:** 36, representing 9029 hand therapists worldwide.
- **Associate members:** Bangladesh, Mexico, Nepal, Philippines, Qatar, United Arab Emirates
- **Corresponding members:** Bahrain, Barbados, Gaza, Ghana, Iran, Qatar, Romania, Saudi Arabia, Sri Lanka (Ghana is new member)
- **Commercial Members:** NCM, Orfit, DanMic Global, Klarity, T-Tape Company and 3-Point products
- **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)

COMMUNICATION

Within IFSHT:

- **Executive committee:** Face-to-face meeting held from June 1-3, 2017 in Hong Kong.
- Plans for next two years were discussed.
- Continue to hold regular Skype-call meetings, every 6 to 8 weeks
- Virtual office is utilized for on-line discussions

and document sharing.

- Passed a motion to restructure fees for all membership categories – now setting up delegate vote
- Passed a motion to appoint an administrative secretary – will start to advertise position
- Discussed potential website enhancements, aimed at providing additional educational resources for therapists
- Agreed to create an Ad Hoc Social Media Committee
- Discussed International Teaching Travel Grant – acknowledged that we were only able to award this grant twice in last triennium, so have decided to increase funds available to \$1500/grant
- **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.
- **IFSHT Hand Therapy Connections E-Newsletter:** 2x per year. Currently, over 2000 subscribers.
- **IFSHT Facebook Page:** 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 included the trip to Ghana by a therapist who received the International Teaching Grant, management of PIP joint injuries and management of the chronically painful wrist.

IFSHT AWARDS

- **Evelyn Mackin Award was established in 2010:** sponsorship of a therapist(s) from a developing

country (GNI < \$6000) to attend triennial congress.

- **Christine Alegri Award for innovation in hand therapy** awarded in 2016 for the first time in Buenos Aires to Birgita Rosen for her work (STI test for assessment of tactile gnosis & Sensory Glove System).
- **The inaugural Lifetime Achievement Award will be awarded in 2019** to honor those who have made a global impact on profession of hand therapy

SPONSORSHIP ACTIVITIES

- **IFSHT-IFSSH International Hand Therapy Teaching Awards (increased to a maximum of \$1500 each):** Available for therapists travelling and teaching (clinical or academic) in areas of the world with limited hand therapy access.
- **Dynamometers (donated to IFSHT):** ~ 70 dynamometers available. Available to therapists or surgeons travelling and teaching / consulting in a developing country. To request a dynamometer, please contact secretarygeneral@ifsht.org. In 2016/2017 dynamometers have been sent via projects to the following countries: Nepal, Kosovo, Zambia, Czech Republic and Brazil.
- **Evelyn Mackin Award:** As mentioned, five therapists from: Chile, Mexico, Ecuador, Nepal, Philippines) were fully sponsored to attend 2016 IFSHT-IFSSH Congress.
- **International Therapist Triennial Meeting Sponsorship Funds (as available):** assists international therapists to attend the IFSHT triennial congress. IFSSH donated \$5000 toward therapist registration fees. In total, \$7200 was received from IFSSH, commercial entities, hand therapy organisations and numerous individuals. These funds supported 16 therapists to attend the Congress, from the following Australia, Brazil, Colombia, Czech Republic, Estonia, Iran, Kenya, South Africa, Spain, United Kingdom and Venezuela.

REPORT OF THE SOUTH AMERICAN FEDERATION OF SOCIETIES FOR SURGERY OF THE HAND

The Federation was very active in the organisation of the 13th Congress of the IFSSH in Buenos Aires in October 2016.

A large number of registrants from South America participated.

From 27 to 29 of April 2017 the Federation was involved in the XI IBERO LATIN AMERICAN Congress held in Puerto Rico.

The 16th South American Federation Congress was held in Buenos Aires from 11th to 13th October 2017.

At the FESSH Meeting in Copenhagen in 2018, South America will do a presentation to host the 2025 IFSSH Congress.

Eduardo Rafael Zancolli
 Delegate for the South American Federation



Participants in the 10th annual meeting of the Egyptian Society for Surgery of the Hand and Microsurgery that was held in Cairo April 4-6,2017.

EGYPTIAN SOCIETY FOR SURGERY OF THE HAND AND MICROSURGERY (ESSHM)

Nash Naam. The Egyptian Society for Surgery of the Hand and Microsurgery celebrated its 10th anniversary during an international hand surgery conference held in Cairo on April 4-6, 2017. Many international hand surgery leaders participated in that conference including surgeons from USA, Germany, Romania and South Korea.

ESSHM continues to grow and to be more inclusive in getting hand surgeons from the Middle East, the Arab World and North Africa to be welcomed under its umbrella. It strives also to strengthen its relationship with other local hand surgery and Microsurgery societies. As a result, the Pan Arab Federation of Societies for Surgery of the Hand (PAFSSH) was formed to include Hand surgeons from across the Arab World.

PAFSSH held its first meeting along the meeting of ESSHM in Cairo. Furthermore, the Pan Arab Federation of Societies for Reconstructive Microsurgery (PAFSRM) was also formed and it will hold its first annual meeting in Beirut, Lebanon, in September 2018.

ESSHM has 2 annual meetings, one in Cairo in April and the other one is in Alexandria in October in addition to several smaller meetings in different cities in Egypt.

ESSHM has also been accepted as an associate member of the European Federation of Societies for Surgery of the Hand. Many members of ESSHM participated in the FESSH meeting with several oral and poster presentations.

INDIAN SOCIETY FOR SURGERY OF THE HAND (ISSH)

The 41st annual meeting of the ISSH was held in Mumbai from 21st to 23rd September 2017 at the JW Marriot Hotel, Juhu with Dr Pankaj Ahire as the congress chairman.

This year the Singapore Society for Hand Surgery was the guest society and this is the first time SSSHS became a guest society. The meeting had 356 participants and is one of the highest recorded so far. The ISSH has two named orations – Prof Venkataswami Oration delivered by Prof Richard Gelberman from the USA and the Prof BB Joshi Oration delivered by Prof Jayme Bertelli from Brazil.

The Robert Acland and S & T international Fellowship, established 6 years ago from the sale proceeds of Dr Acland's Microsurgery practice manual, and the Inland Travelling Fellowships serve as important academic activities of our Society.

We have started to combine the Hand Therapist Meeting with the surgeons meeting. This year the meeting attracted 55 therapists.

The next annual meeting of the ISSH will be held in Coimbatore between the 5th and 7th October 2018.



The Local Organizing Committee with Prof Richard Gelberman, the “2017 Prof R Venkataswami Orator”

www.ifsht.org | info@ifsht.org

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SPOTLIGHT ON IFSHT MEMBER SOCIETY: HONG KONG

The Hong Kong Society of Hand Therapy (HKSHT), formed in 2007, promotes hand therapy services and now has more than 60 members. HKSHT is partnered with the Hong Kong Society for Surgery of the Hand (HKSSH) to organize an annual joint conference. In March 2017, the HKSHT and HKSSH jointly organized the 7th Annual Hand Therapy Symposium on "Rehabilitation of the Stiff Upper Limb: from Theory to Evidence Based Practice." Shrikant Chinchalkar from Canada was the guest speaker for instructional lectures and a workshop. Local surgeons, anesthesiologists and therapists shared the latest updates in this topic. Participants had very positive response on this symposium. Additionally, the HKSHT regularly conducts workshops to enhance the knowledge and practice of hand therapy.



(L to R) Ms. Eva Ma (External Secretary), Ms. Carrie Cheng (Treasurer), Mr. Lewis Lau (Chairman), Dr. Lau Y.K. (Hand Surgeon), Ms. Casie Chan (Past President), Ms. Josephine Wong (Education Secretary).

APPLY FOR AN IFSHT INTERNATIONAL TRAVEL GRANT

The IFSHT International Teaching grant has increased to \$US1500. The grant provides support to experienced hand therapists who provide hand therapy training in developing countries. Read about the grant and download the application from www.ifsht.org/page/international-teaching-grants-0.

EUROHAND, BUDAPEST, JUNE 2017

The European Federation of Societies for Hand Therapy (EFSHT) held their triennial meeting in combination with FESSH and the Hungarian Society of Hand Surgery. The congress theme was "Evidence Based Hand Surgery and Therapy." While attending the meeting, Anne Wajon, IFSHT Presi-



(L to R): Isabell Faad (Representative of Intercongress), Natascha Weihs (DAHTH President), Hanne Wendt, Dominik Simon, Beate Jung, Christine Popp (DAHTH Local Organizing Committee), Saara Raatikainen (EFSHT President), Anne Wajon (IFSHT President) and Prof. Dr. Jörg van Schoonhoven (DGH Local Organizing Committee).

dent, met with the organisers of the IFSHT/IFSSH Congress in Berlin in 2019 (photo).

After the meeting, Anne Wajon visited Milada Cincerova at her clinic in Prague. Anne and her daughter Sally discussed the management of CMC joint osteoarthritis, and various management approaches for complex injuries. Find a clinic to visit on your international travels on the IFSHT website: www.ifsht.org/page/visit-clinic.

ASIA PACIFIC FEDERATION OF SOCIETIES FOR HAND THERAPY (APFSHT)



APFSHT, founded in 2004, is led by president Dr. Seiji Kanazawa (Japan), and Mr. Kent Chang (Taiwan), Prof. Cecilia Li, and Mr. Hercy Li (Hong Kong). The 7th APFSHT Conference with the 11th APFSSH Conference will be held on 7-10 November in Cebu, Philippines. Mr. Jose Ramos (chair), with the newly formed Philippine Hand Therapists Society, will host the meeting. Details: www.handsociety.org.

IFSSH EZINE

The IFSHT contribution to the IFSSH August 2017 EZINE is "Challenges in Managing Scars on Pediatric Burnt Hands," by Ms. Yating Wei and Prof. Cecilia WP Li-Tsang. Highlighted is the Smart Scar Care Pad, created by Prof. Li to manage dorsal hand/web scars.



Please submit your articles to presidentelect@IFSHT.org.

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



“HAND CLINICS”

VOLUME 33, ISSUE 3, AUGUST 2017, P473-487
 “THE NON-OPERATIVE MANAGEMENT OF HAND FRACTURES IN UNITED KINGDOM”



Professor Grey Giddins
 Consultant Orthopaedic and Hand Surgeon
 Visiting Professor University of Bath
 Editor-in-Chief Journal of Hand Surgery (European) (2012 -2016)
 President of the British Society for Surgery of the Hand

What were your main reasons for writing this article?

I was particularly keen to write this article to highlight the success of non-operative management of many hand fractures and to emphasise that we should only be operating if we are confident that the non-operative outcome will be poor or that we can reliably improve upon the non-operative outcome with surgery. For some cases that is clear cut, such as a complex open fracture into a joint or a combination of bone and soft tissue injuries. Otherwise the hand is often very forgiving of injury and with early mobilisation many patients achieve a very good outcome. In addition, the most specular complications seem to occur following operative treatment of fractures rather than neglected fractures. I recognise that I have a bias in this, part of which may be due to the nature of

the health service in the UK where there is less incentive to operate and a greater incentive not to operate. Nonetheless with so much emphasis on operative techniques in many journals and text books, as well as promotion by companies who make implants, there is much greater encouragement and interest in operative treatment than “old fashioned” non-operative treatment. I felt it was right to try to redress this a little.

What are the most interesting/important results and conclusions of your article?

There is not an awful lot which is especially new in this article save the concept of gliding for fractures of the bases of the middle and distal phalanges. What I have aimed to do is to distil the knowledge gained over many years highlighting some

of the fractures which do so well with non-operative treatment that it is highly unlikely that any operative treatment will improve on that outcome. This is well recognised for metacarpal neck (boxers) fractures and for transverse shaft fractures. My colleague Aman Khan and I recently published (Khan and Giddins 2015) the outcome of early mobilisation of spiral metacarpal fractures which almost always gives an excellent outcome. I have also published in the management of finger proximal phalanx collateral ligament avulsion fractures (Sawant et al 2007), which do very well with early mobilisation. This is true of other ligament avulsion injuries such as around the thumb, especially if there is a bony fragment. Yet for all of these injuries there are many published articles recommending operative treatment and even some articles stating that non-operative treatment should not be performed. This sort of “authority” encourages less experienced surgeons to potentially undertake unnecessary surgery, even if only to be seen to “do something”.

Recently I have shown that with hyperextension testing, it is possible to identify those bony mallet injuries that are likely to do well, i.e. glide or tilt, rather than those that pivot, which are likely to do less well. Ongoing research for base of middle finger (PIP joint) injuries suggest this is also true, i.e. if they glide on lateral flexion radiographs then surgery appears unnecessary.

That is a more common group where surgery has more often been recommended. It would appear that the key is not restoration of anatomy but restoration of gliding, even with a widened base of the middle phalanx. This is not however so well established and at the moment is a theory being tested.

Gray Edwards and I undertook a systematic review of the management of Bennett’s fractures (Edwards and Giddins 2016). Although surgery has become the mainstay treatment with some authors feeling that non-operative treatment is “negligent” the published literature does not support this. It seems that there is a very similar outcome with operative and non-operative treatments. Whilst I would not advocate doing nothing, I think that appropriate non-operative treatment with immobilization in a plaster cast can often lead to a satisfactory reduction of the joint and fracture; provided this is maintained over at least 2 and probably 3 weeks. Immobilisation in plaster for 5-6 weeks would probably suffice and give a good outcome. This may only be for half of all Bennett’s fracture, but even that will ensure that many patients will avoid the risks, complications and costs of surgery.

In addition I think that many, if not most of these injuries, will have subsets where surgery is preferable to non-operative treatment. We in hand surgery have often not

managed to identify these subsets so that we have tended to overtreat having been disappointed with non-operative treatment of some of these injuries. Bony mallet injuries are notable examples, e.g. in treating all bony mallet fractures with a dorsal fracture fragment of one third or more (as advocated by many authors) we cause considerable over treatment but there are some fractures that do need surgery. We need to identify better those cases that need surgery as against those that do not.

What should all hand surgeons and all hand therapists who read your article understand about the findings of your research question?

I think this is a very good question. It is easy for people to misunderstand the messages one is trying to convey. I am not saying that no hand fractures should be operated on or that people who operate on more hand fractures than I, are performing unnecessary or bad treatment. Plainly I think that the way I manage hand fractures is the best way otherwise I would not do it, but other surgeons doing it differently will believe that they are giving the best treatment.

I want surgeons and therapists to understand the natural history of these injuries: the outcome of non-operative treatment and where those outcomes are poor, then consider surgical intervention. Where the outcomes are very good

or excellent, then the indications for surgery are very limited, although surgeons and therapists should continue to look out for subsets of these injuries which may benefit from surgery. In addition in clinical practice I acknowledge that there may also be specific individuals who are either unsuited to having a period in plaster or cannot re-attend for outpatient follow-up and may therefore benefit from surgery but those are exceptions in my experience.

I think it is also important to understand that non-operative treatment does not mean no treatment. For many of these injuries I will see patients weekly for at least the first 3 weeks following their injury to ensure they are maintaining/regaining an adequate range of motion and the joint is not subluxing and continues to glide, such as for injuries at the base of the middle and distal phalanges. Patients need to be re-educated and encouraged in the use of their injured hand; that can take quite a lot of time and effort for some patients, although less so for others.

I also do not believe that this review is the "definitive answer" for the management of these hand fractures. In time techniques will develop and it may be that there will be superior surgical techniques which will give such good early stability with such low risks that for some injuries the outcomes will be appreciably better with surgery than non-operative

treatment, so a surgeon writing this article in 20 or 30 years will write a different article. Nonetheless the understanding of the outcome of non-operative treatment provides the base line from which to move forward our clinical practice and research.

Will you be conducting further research or publishing further work on this topic? If so, what will it entail?

I am looking at bony mallet injuries a little further. I think that these are not avulsion injuries as has been suggested but almost certainly dorsal impaction injuries. I am not unique in believing this but I am hoping to pull some further evidence together to confirm this. If so, that would suggest that splinting them in extension, particularly hyperextension is illogical and risks further destabilisation as shown by the hyperextension stress tests that I have done. It may be that it is better to splint the DIP joint in mild flexion of around 10 degrees and this will reduce further the need for surgery.

I am hoping to conclude the first phase of my research looking at gliding and PIP joint injuries, i.e. fractures of the base of the middle phalanx and show that many of these which look bad radiologically do very well clinically, provided they glide rather than pivot. Again this will be emphasising a sub-group who do not need surgery. Exactly why some of them do glide so well

despite quite a lot of displacement is unclear but we are looking into some biomechanical research to try to elucidate that.

I am also trying to get a better understanding of why some injuries are avulsion injuries and some are impaction injuries; I suspect is primarily related to degrees of restraint around joints.

Finally I am trying to understand better the optimal non-operative treatment of extension fractures of the base of the proximal phalanx. This is a common injury, particularly in older patients, often well tolerated but with an appreciable risk of CRPS especially if held down too flexed to reduce the fracture. I have tried many different non-operative techniques including free mobilisation, strapping and plasters and I am trying to understand them better.

I would like all authors of chapters/textbooks on the management hand and wrist fracture to describe in detail the non-operative treatment they use before describing the operative techniques. Often the texts refer to "non-operative" or "conservative" treatment but give little details on exactly what that entails such as immobilization techniques, positioning of immobilization, length of time, frequency and length of review etc.

Thank you for asking me to answer these questions

VOLUME 33, ISSUE 3, AUGUST 2017, P545-550 "PERIPHERAL NERVE DEFECTS"



Bruno Battiston
Head of Orthopaedic, Hand Surgery , Microsurgery Unit - C.T.O. Hospital, Torino, Italy
Professor of Hand Surgery and Microsurgery in Orthopaedic School of Torino University
President of the Italian Society for Surgery of the Hand (SICM)

What were your main reasons for writing this article?

The reason for writing this article was mainly our interest in updating this field of nerve reconstructive surgery. There are many new proposed techniques in the experimental field and in clinical practice but still there is a lack of consensus regarding nerve gap reconstruction. Secondly, there was a prominent promotion of the European experience and experimentation which was

influenced by European pioneers (Millesi and many others) and by the local health systems. These are not always possible to be practically implemented. As an example, allografts and some synthetic conduits which were popularised cannot be utilized everywhere due to different laws or regulations in the different European countries.

What are the most interesting/important results and conclusions of your article?

Focusing on the several types of reconstructions which are performed to fill nerve gaps, we conclude that the results of the clinical application of the many experimental options eg. biological and synthetic conduits or allografts, are not always as promising as suggested. The gold standard still seems to be autografts. However, when the nerve defect is severe, and autografts are not the appropriate choice because it may likely give a poor result, the use of reconstructions such as nerve transfers and end-to-side sutures may be considered valid alternatives.

What should all hand surgeons and /or hand therapists reading your article understand about the findings of your research?

This article hopes to emphasise that

decision making in the treatment of nerve defects is still based on the clinical experience of the surgeon which takes into account the timing of referral (acute or delayed), the level of the injury (proximal or distal), the type of lesion (closed or open, neat or blunt), and the size of the nerve gap.

Will you be conducting further research/publishing further work on this topic? If so, what will it entail?

There are a lot of things to be clarified and our understanding of how nerves function and heal after injury. Our hope is that all the experimentation will lead to new perspectives with promising results. This is the reason why many research centers, as also in our department, will continue to study and investigate the fascinating field of nerve repair and regeneration.

Tips & Techniques

THE CHOICE OF A DONOR MUSCLE FOR RESTORATION OF ACTIVE ELBOW FLEXION IN CHILDREN WITH AMYOPLASIA

Elbow contractures are one of common pathologies in patients with arthrogryposis (92%). More than 90% of patients have an extension contracture. The elbow joint assists the hand to move towards and from the body. Elbow flexion makes it possible to bring food to mouth, to perform hygiene and in dressing.

Most of the activities of daily living can be accomplished within 70 degrees of elbow flexion, known as the "useful arc" of elbow flexion (ie. from 140 to 70 degrees) (fig 1), and 100 degrees of forearm rotation (ie. 50 degrees of pronation and 50 degrees of supination).

The aim of surgical restoration of elbow flexion is to achieve less than 90 ° of passive flexion ie within the "useful arc" of elbow motion.

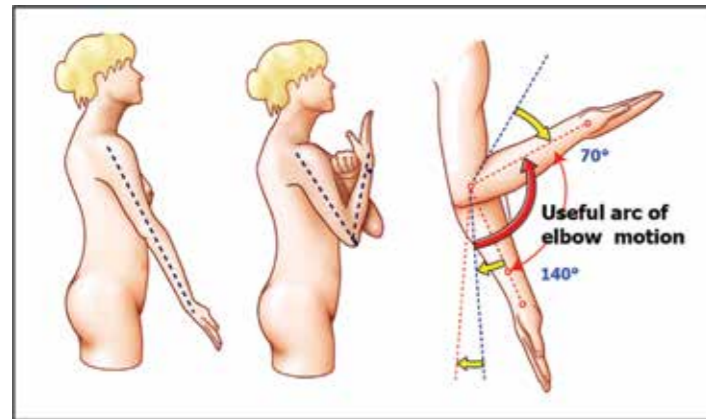


Fig 1. Useful arc of elbow motion

In order to have a comprehensive evaluation of the patient's functional ability of the upper limb, we classify according to the spinal level of affliction, and also note the functionality of the various joints and movements (table1).

Table 1.

	C6	C6-C7	C5-C7	C5-Th1
Shoulder			●	●
Elbow	●	●	●	●
Wrist		●	●	●
Hand		■	●	●
Rotation deformities		●	●	
Self-ability problems	■	■	■	●

● Insufficient function ■ Possible insufficient function
 Variation of upper limb deformities in amyoplasia linking with the level of spinal cord injury

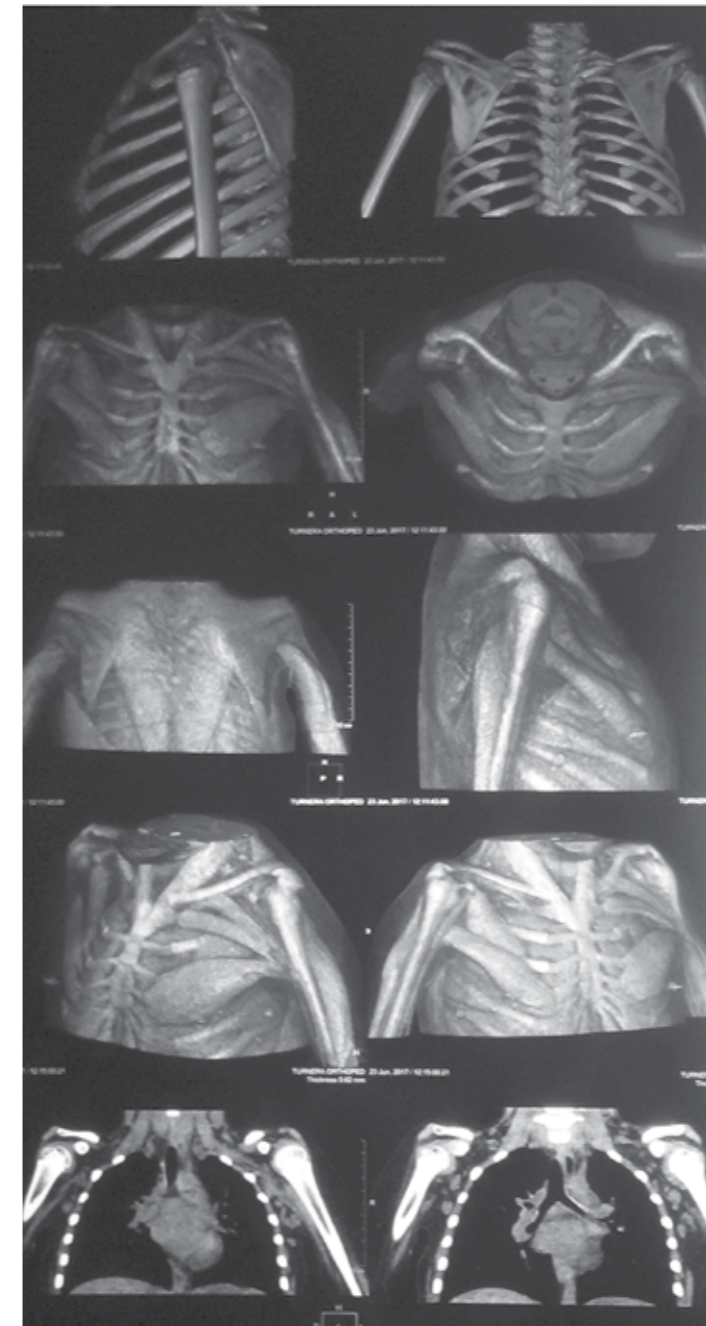
We found the optimal age for operative treatment to be between ages 1-3 years. The choice of a donor muscle for children with amyoplasia is extremely limited. Most authors recommend using muscles around the shoulder for this purpose: latissimus dorsi (LD), pectoralis major (PM) and triceps brachii (TB). If possible we prefer to use LD. The M.triceps brachii has to be grade 3 or more in patients with amyoplasia, but our outcome results demonstrate elbow flexion contractures in cases with TB transfers and therefore nowadays we use only the long head of triceps brachii (LHTB) for restoration of active elbow flexion.

How does one choose an optimal donor muscle for active elbow flexion? Some diagnostic methods which are suitable for adults are difficult to perform in children (for example clinical examination and EMG).

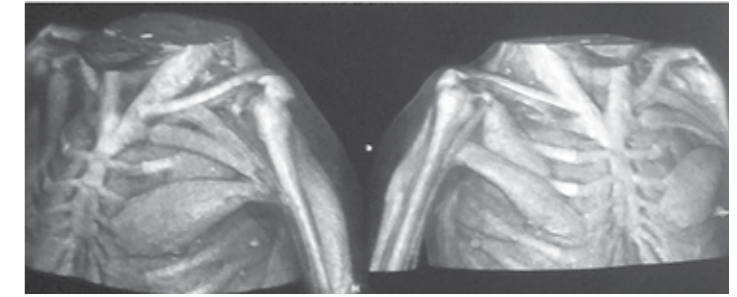
To solve this problem, we use the following guidelines:
 1. We estimate the level of spinal cord injury and choose the optimal muscle:

C6 – LD, C6-7 - LD or PM, C5-C7 - LD or PM , C5-Th1 - PM or LHTB).

2. A CT scan is done of the thorax, and shoulders. This method reveals not only the soft tissue and bone deformities, but more importantly the potential available muscles in one examination. This scan is cheaper, and much easier to perform than a MRI. The CT scan can identify the available muscles, their position, structure and size (fig.2 A and B)



A - CT of a patient with amyoplasia.



B - CT of thorax (on the right side only the costal segment of the PM is present, on the left side the clavicular, manubrial and a hypoplastic sternocostal segment of the PM is present).

3. Intra-operative testing: a small incision is made over the potential donor muscle. The muscle is then stimulated. If you see good muscle tissue and a good muscle contraction, this is an ideal prognostic sign.

4. If the donor muscle is only a grade 2-3, we usually use two muscles (eg. pectoralis major and minor muscles, or PM and LHTB).



Olga Agranovich,
 Head of the Arthrogryposis Center
 The Turner Scientific and Research Institute for
 Children's Orthopaedics. St. Petersburg, Russia

IFSSH Sponsorships

SYMPOSIUM: "SURGERY OF THE SPASTIC UPPER LIMB" PARIS, 10-11 MARCH 2017

PURPOSE OF THE SYMPOSIUM

Although surgery has been performed in the management of spasticity of the upper limb for many years, it has not developed much until there was increased awareness of its potential several years ago, thanks to new concepts and new approaches.

This meeting, which to the best of our knowledge was the first of its kind, aimed at gathering specialists involved in the surgical care of the spastic upper limb, in order to exchange our surgical experiences and outcomes, and hopefully to clarify the indications of this highly specialized surgery. For this purpose, besides asking world renown specialists for several lectures each, we included in the faculty whoever wanted to share their experience, amounting to a faculty of 49 (see list attached)

The second goal of the meeting was to inform all related specialists (physiatrists, physical and occupational therapists) of the surgical possibilities, which unfortunately still remain widely ignored or have a negative reputation in many teams around the world. And for this purpose, we designed an ambitious program dealing with all aspects of surgery for the whole upper limb.

ATTENDANCE

The response to the advertisement for this Symposium was extremely positive, and registration was already fully booked one month prior to the meeting. Thanks to the generous sponsorship from the IFSSH, we were able to secure a second room with simultaneous projection which allowed 30 more participants to subscribe.

Altogether, 180 people attended the meeting, coming from 48 different countries. Thanks to the IFSSH sponsorship, we were also able to help five attendants with their lodging, and waive the registration fees for the faculty, and 10 more attendants with limited resources.

CONTENT

The content of the Symposium was very dense, but thanks to the faculty who stuck carefully to their speaking time, there was plenty of time for discussion, which was well received by the audience. Although no formal evaluation was performed after the meeting, the large feedback we received was extremely positive.

FUTURE PERSPECTIVES

A frequent question after the Symposium was about the next meeting..... There seems to be a wide interest in continuing this program, both for scientific and educational purposes. It is our feeling that a formal group should be created around this subject, and that a regular encounter (for example every other year) should be planned.

ACKNOWLEDGEMENT

This Symposium would not have been possible without the support of the members of the faculty who all came at their own expenses, sometimes from very far away, and we are extremely thankful to all of them. We are also very grateful to the IFSSH, whose sponsorship allowed us to increase the attendance, to waive a number of fees, and to keep expenses under control, with a final positive balance (300 €)

International Symposium on Surgery of the Spastic Upper Limb
Paris, 10-11 March 2017

Chairman : Caroline LECLERCQ (Paris, France)

Scientific Committee: Michael TONKIN (Sydney, Australia)

Organizing Committee: Mathilde GRAS (Paris, France)

Faculty

1. Yves ALLIEU (Montpellier, France)
2. Nathalie BINI (Padova, Italy)
3. Adeline CAMBON-BINDER (Paris, France)
4. Emmanuelle CHALEAT-VALAYER (Lyon, France)
5. Christopher COLBORNE (London, UK)
6. Elena COSENTINO (Venice, Italy)
7. Bertrand COULET (Montpellier, France)
8. Philippe DENORMANDIE (Garches, France)
9. Marybeth EZAKI (Dallas, USA)
10. Sybille FACCA (Strasbourg, France)
11. Frank FITOUSSI (Paris, France)
12. Sabrina GALLEGO (Medellin, Colombia)
13. Werner GIRSCH (Vienna, Austria)
14. Hyuinsic GONG (Gyeonggi-do, Korea)
15. Jean-Michel GRACIES (Créteil, France)
16. Mathilde GRAS (Paris, France)
17. Claudia GSCHWIND (Sydney, Australia)
18. Christian HAGEMANN (Hamburg, Germany)
19. Vincent d'HARDEMARE (Paris, France)
20. Steven HOVIUS (Rotterdam, Netherlands)
21. Cyril JAMES (Paris, France)
22. Serdar KOCER (Porrentruy, Switzerland)
23. Scott KOZIN (Philadelphia, USA)
24. Mick KREULEN (Amsterdam, Netherlands)
25. Isabelle LAFFONT (Montpellier, France)
26. Françoise LAPIERRE (Poitiers, France)
27. Melinda LEWIS (Brisbane, Australia)
28. Aleksandar LOVIC (Madrid, Spain)
29. Patrick MERTENS (Lyon, France)
30. Nadine NACHEF (Lille, France)
31. Türker OZKAN (Istanbul, Turkey)
32. Paolo PANCIERA (Treviso, Italy)
33. Catalina PAROT (Santiago, Chile)
34. Renata PAULOS (Sao Paulo, Brazil)
35. Simon PICKARD (Oswestry, UK)
36. Eva PONTEN (Stockholm, Sweden)
37. Michael POSCHMANN (Munich, Germany)
38. Carina REINHOLDT (Goteborg, Sweden)
39. Francisco SOLDADO (Barcelona, Spain)
40. Ann VAN HEEST (Minneapolis, USA)
41. Claire VILLEPINTE (Toulouse, France)
42. Carley VUILLERMIN (Boston, USA)
43. Daniel WEIGL (Tel Aviv, Israel)
44. Paolo ZERBINATI (Castellanza, Italy)
45. Maxime HORWITZ (London, UK)
46. Ahlam ARNAOUT (Paris, France)
47. GEFRIER (Garches, France)
48. Rachel BARD (Lyon, France)
49. Laure GATIN (Garches, France)



Round Table discussion: left to right Isabelle LAFFONT (France), Françoise LAPIERRE (France) and Claudia GSCHWIND (Australia)



Former residents of the Institut de la Main. Left to right: Adeline CAMBON-Binder (France), Paolo PANCIERA (Italy), Catalina PARROT (Chile), Renata PAULOS (Argentina), Caroline, Sabrina GALLEGO (Columbia), Nathalie BINI (Italy)



Caroline experimenting the latest technology

Turker OZKAN (Turkey) and colleagues

IFSSH generously contributed to the following efforts:

IFSHT-IFSSH International Hand Therapy Teaching Awards: IFSSH donated \$1500 of the total \$4500 allocated for these awards during this term.

Rajani Sharma visited Komfo Anokye Teaching Hospital (KATH) in Ghana from August 15-20, 2016.

Report published in the April 2017 IFSSH Ezine (attached). Received \$1000.

Milada Kukackova applied on behalf of the Czech Hand Therapy Society to fund Sarah Mee and Nicola Goldsmith to hold a splinting course at the Hotel Sklňř, Harrachov in November 2015. Received \$1000.

- Day 1 of the course covered functional anatomy, hand assessment for splinting, thermoplastics and their properties, principles of static splinting, pattern making and principles of strapping.

- Day 2 covered pattern making for elbow and POSI splints, theory of tissue stretch, and pattern making for thumb splints.

Evelyn Mackin Triennial Award: IFSSH donated \$3000 of the total \$16,113 which was received from various donors. Supported the following therapists to attend the Congress.

Marcela Antunez (Chile)

Gabriela Granados Garcia (Mexico)

Patricia Llaguno (Ecuador)

Tarannum Siddiqui (Nepal)

Jose Ma. Rafael Ramos (Philippines)

IFSHT Triennial Congress Travel grant: IFSSH donated \$5000 toward therapist registration fees. In total, \$7200

was received from IFSSH, commercial entities, hand therapy organisations and numerous individuals.

These funds supported 16 therapists to attend the Congress, including:

Bronwen Ackerman from Australia

Raquel Cantero from Spain

Elvia Gonzales from Colombia

Kathryn Johnson from UK

Milada Kukackova from Czech Republic

Liis Lamsom from Estonia

Tatiani Marques from Brazil

Carolina Molano from Colombia

Erastus Shuma from Kenya

Taryn Spark from South Africa

Paola Bernal from Colombia

Claudia Montoya from Colombia

Roxanne Wentzel from South Africa

Elham Sadeghein from Iran

Daniela Gola from Brazil

Antonieta Larez from Venezuela

Statistical Advisor Vacancy

The Journal of Hand Surgery (European Volume)

Impact Factor: 2.191

Frequency: Nine times per year

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Current practice

In most papers the statistical analysis is either very simple (perhaps not always correctly so) or not needed. The Editorial team deals with those papers without needing to consult the Statistical Advisor.

Some papers require statistical advice typically requested by the Editor assigned to the paper or recommended by a reviewer. The paper is sent via our online system to the Statistical Advisor who reviews the paper and particularly the statistical analysis. The Statistical Advisor will typically respond in one of three ways:

- Approving the statistical analysis completely or in large part.
- Recommending appreciable changes.
- Recommending rejection of the paper based upon fundamental statistical or other flaws.

There is time pressure in processing submissions so the Statistical Advisor will be expected to respond within 14 days of request (leave and other commitments permitting).

The recommendation will be read by the Editor and as appropriate passed on to the authors. If major changes have been requested, the Statistical Advisor may be asked to review the revised paper to approve the changes.

It is likely that over time the number of requests will increase as studies become more complex. There is considerable opportunity for expanding the role depending upon the interests and availability of the Statistical Advisor.

About the role

The role of the Statistical Advisor is an honorary post to support the editorial team in assessing and improving the statistical analysis in papers under consideration for publication.

Requirements

- A strong knowledge of statistical methods with training up to at least degree standard.
- A knowledge of surgical practice with preference for plastic or orthopaedic surgery and ideally hand surgery.
- Sufficient time to fulfil the role.
- The ability to work fully online with our Editorial Manager system (with appropriate training and support).

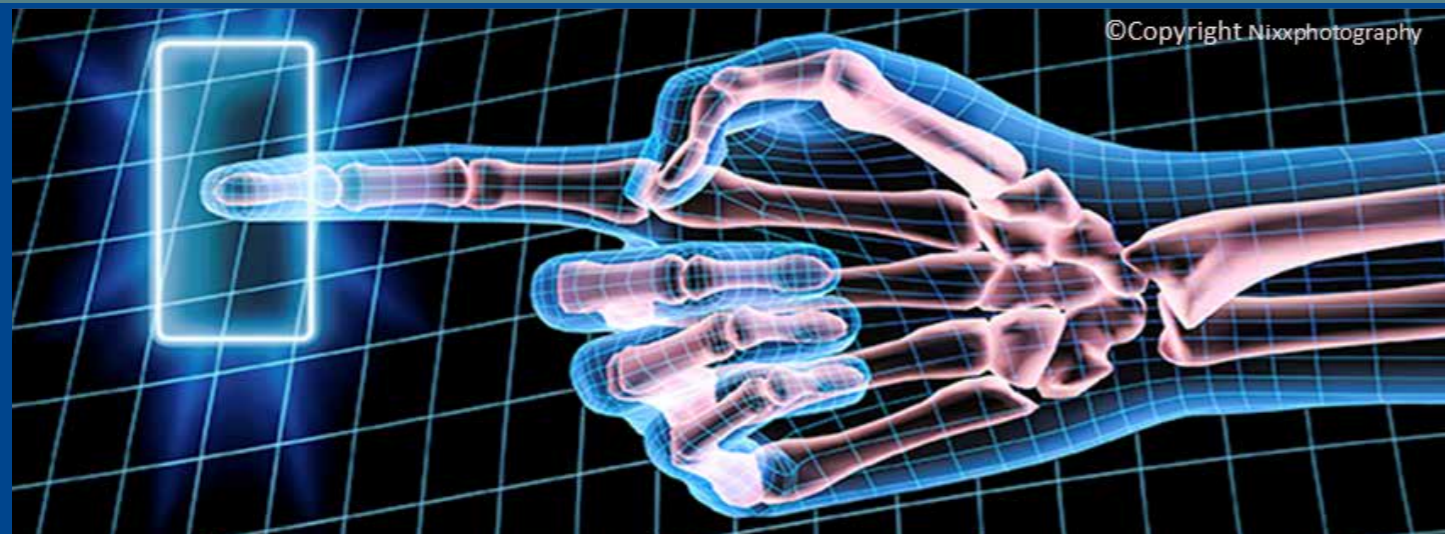
Term

The post is appointed for 5 years in the first instance, renewable once with mutual agreement. There will be reviews at 6 months, one year and yearly thereafter to make sure the appointment is working well for the Journal and the Statistical Advisor. There will be a minimum notice period of 6 months.

How to apply

All enquiries and expressions of interest should be directed via email in the first instance to: editor@journalofhandsurgery.com.

The closing date for applications is midnight on the **15th of November 2017**.



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Hand Surgery Evidence Updates are compiled by the Centre for Evidence Based Hand Surgery at the University of Nottingham, with support from the University of Nottingham, Nottingham University Hospitals NHS Trust and the British Society for Surgery of the Hand (BSSH).

Dear Colleagues, Hand Therapists and Friends,

It is our pleasure and privilege to invite you to the 16th National Congress of the Turkish Hand and Upper Extremity Society, and the 5th National Congress of the Hand Therapists Society which will be held in Pamukkale, Denizli, TURKEY on May 2018.

We are looking forward to your attendance to our congress where you will also be able to visit Hierapolis-Pamukkale which is a UNESCO World Heritage Site since 1988.

Congress attendees will have the chance to benefit from scientific exchange during meetings and visit one of the natural wonders of our country.

Yours sincerely



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World Symposium of Congenital Malformations of Hand and Upper Limb 2018

cum 31st Annual Congress of the Hong Kong Society for Surgery of the Hand

Venue: Harbour Grand Kowloon Hotel
Abstract Submission Deadline: 31 August 2017
Early Bird Registration Deadline: 31 October 2017

7-10 MARCH 2018
(WEDNESDAY - SATURDAY)
HONG KONG

ABSTRACT CATEGORIES

Antenatal diagnosis and treatment	Arthrogyposis	Basic research, gene therapy	Cleft hand	Complication of treatment, Keloid
Fingers anomaly	Hypoplastic thumb	Longitudinal deficiency	Overgrowth syndrome, genetic basis	Polydactyly
Rehabilitation and Outcome measure	Syndactyly, Complex syndactyly, Apert syndrome	Transverse deficiency	Use of IT on management of CULA, Telemedicine	HKSSH Annual Congress free papers

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