**Abstracts**

*prof. Steven L. Moran*

Ligament injuries in the wrist: Do we need repair them all?

The original description of carpal and scapholunate (SL) instability were described by Linscheid and Dobyns over 40 years ago.  Since that time a “gold standard” has yet to be established for the treatment of scapholunate instability of the wrist.  This lecture will provide a brief overview of SL instability and the recent advances in diagnosis and surgical treatment.  We will also explore the paucity of evidence based outcomes studies for the treatment of SL instability and suggest what can be done to improve our outcomes of this pathologic process.

*prof. Peter C. Amadio*

***Fact and fiction in flexor tendon surgery***

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This presentation will update attendees on current tissue engineering techniques to enhance the intrinsic pathway of tendon healing, suppress the extrinsic pathway of healing, and improve  frictional resistance to tendon gliding(1-3).  It will also review the current practice for core suture methods(4-7); pulley management(8, 9), tendon rehabilitation and considerations for FDS repair(10). Finally, the presentation will review the limitations and pitfalls of current methods of tendon repair and reconstruction.

References

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*prof. dr. Haustvedt*

The distal radio-ulnar joint: what have we learned from its complex anatomy?

The distal radioulnar joint (DRUJ) allows man to rotate the forearm to place the hand in a desired position to perform different tasks, without interfering with the grasping function of the hand. The ulna is the stable part of the forearm around which the radius rotates; the stability of the DRUJ is provided by the interaction between ligaments, muscles and bones. The stabilizing structures are the triangular fibrocartilage complex, the ulnocarpal ligament complex, the extensor carpi ulnaris tendon and tendon sheath, the pronator quadratus, the interosseous membrane and ligament, the bone itself and the joint capsule.

During the last decades research has been performed on these different structures and we have learned to understand the importance of each of the structures as well as the interaction between them. The purpose of this talk is to present and illustrate the current understanding of the functional anatomy and pathomechanics of the DRUJ.

*Prof. dr. Dellon*

**CRPS of the upper or lower extremity: surgical treatment outcomes**

**Abstract**

The hypothesis is explored that CRPS I (the "new" RSD) persists due to undiagnosed injured joint afferents, and/or cutaneous neuromas, and/or nerve compressions, and is, therefore, a misdiagnosed form of CRPS II (the "new" causalgia). An IRB-approved, retrospective chart review on a series of 100 consecutive patients with "RSD" identified 40 upper and 30 lower extremity patients for surgery based upon their history, physical examination, neurosensory testing, and nerve blocks. Based upon decreased pain medication usage and recovery of function, outcome in the upper extremity, at a mean of 27.9 months follow-up (range of 9 to 81 months), gave results that were excellent in 40% (16 of 40 patients), good in 40% (16 of 40 patients) and failure 20% (8 of 40 patients). In the lower extremity, at a mean of 23.0 months follow-up (range of 9 to 69 months) the results were excellent in 47% (14 of 30 patients), good in 33% (10 of 30 patients) and failure 20% (6 of 30 patients). It is concluded that most patients referred with a diagnosis of CRPS I have continuing pain input from injured joint or cutaneous afferents, and/or nerve compressions, and, therefore, similar to a patient with CRPS II, they can be treated successfully with an appropriate peripheral nerve surgical strategy.