EUROPEAN SURVEY REGARDING INDICATIONS AND CONTRAINDICATIONS FOR REPLANTATION OF THE UPPER LIMB

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1. The most important informations before the transfer of the patient to the unit in case of secondary referral are :
- Age (68,75 %);
- Affected Side (65,63 %);
- Level (68,65 %);
- Associated Traumas (68,65 %).

No consensus for: Time Of Accident, Type Of Injury, Local Temperature, Bacterial Or Chemical Contamination / Physical damage, Blood AndX-Ray Examination, Associated Diseases, Ischemia Time, Patient's motivation, Psychological Statu, All of them.

2. The required informations should be provided before transferif possible but it is not mandatory (71,88 %).

No consensus for: Yes, Mandatory before accepting the patient, No, it will not change acceptation of the patient.

3. An hypothermic (with refrigerated amputated segment) ischemia period: >6 h for macro-replantations (segments containing muscles) and >12 h for micro-replantations is not an absolute contraindication for micro-replantation (75,00 %) and is not an absolute contraindication for macro-replantation (65,63 %).

4. A normotermic (with amputated segment at room temperature) ischemia period: >4 h for macro-replantations (segments containing muscles) >12 h for micro-replantations is not an absolute contraindication for macro-replantation (65,63 %).

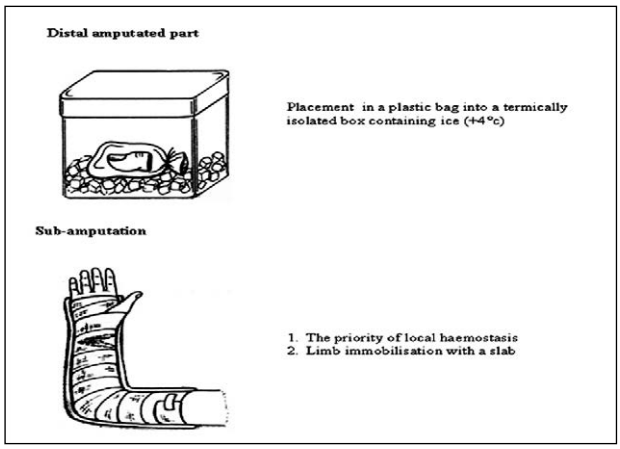
No consensus for: is an absolute contraindication for micro-replantation, is a relative contraindication for: micro-replantation, is a relative contraindication for: macro-replantation, is not a controindication for micro-replantation, is not a controindication for macro-replantation.

5. Only polytrauma (ISS > 15) and organ transplanted patients are relative general contraindications to replantation (68,75 %).

No consensus for: Head Injury (commotive trauma or bad G.C.S.), Age >70 years, Self inflicted injury, Psychiatric disorders, Smoking (not to be considered the occasional smokers), Alcohol overuse, Diabetes.

6. Multiple level injuries (with multiple vascular lesions) (65,63 %), avulsions (with traction lesions of several structures: nerves,vessels, tendons, etc.) (68,65 %) andprolonged ischemia time (>4 hours in macroreplantation —>12 hours for microreplantation (68,75 %) are relative local contraindication to replantation.

No consensus for: Crushing (with extensive tissue damage precluding revascularization with a direct suture), High bacterial contamination, Physical lesion-chemical contamination (frozen burned limbs, contaminated by chemical agen).



7. The following guide-lines regarding the preservation and transportation of amputated segments are important (75,00 %).

8. Single digit replantation (except thumb): (from MP to P2).

No consensus for: Is replantation of a single digit indicated?

9. Distal (distal to FDS insertion) replantation (except thumb).

No consensus for: Is distal replantation indicated?

10. Multiple digits (>2 fingers) replantations.

No consensus for: Do you believe that for this type of replantation a special organisation is required? (double equipe?).

11. The thumb should always be replanted (84,38 %).

12. Age >70 years (78,13 %), smoking (71,88 %) and a distal amputation (68,75 %) are not contraindications to thumb replantation (68,75 %).

No consensus for: Polytrauma (ISS > 15), Crushing, Avulsion.

13. Very proximal level of injury (proximal to the elbow) (71,88 %),transarticular amputations (78,13 %) and amputations through neuromuscular junction (68,75 %) are not local contraindications for major limb replantation.

No consensus for: Multiple level, Type of injury: crush, avulsion.

14. A standardized protocol of adjuvant medical therapy in replantation is useful (81,25 %) and should include heparin (65,63 %) and acetylsalicylic acid (78,13 %).

No consensus for: Low-molecular weight dextran, Sympathetic blocks, Vasodilators.

15. Leeches as non medical adjuvant therapy in microreplantations are useful (75 %).

No consensus for: Decongesting incisions, Nail-bed incisions.

16. The useful indicators to assess the final results after replantation surgery are: Semmes Weinstein sensibility test (68,75 %), Motor function of the reinnervated muscles (78,13 %), Articular range of motion (active and passive) (75,00 %), Pinch and Jamar test (68,75 %), DASH or other objective / subjective evaluation (71,88 %).

No consensus for: Weber sensibility test, Cold intolerance, all of them.

17. The complications to be used as parameters to value indicationsto replantation are: % of survival (75,00 %) and poor motor and sensory function (65,63 %).

No consensus for: % of infections, % of intolerance, % of non union, All of them.

18. The best classifications to assess functional results in upper limb replantations are: Jones 1982 (65,63 %) and Blomen 1988 (65,63 %).

No consensus for: Chen 1978, Berger 1980, Tamai 1982 / 1983, Milroy 1991.

World Society for Reconstructive Microsurgery

Dear Friends and Colleagues-

I have taken the opportunity to prepare this greeting and «Welcome to Mumbai» on Christmas day 2013. The WSRM is made up of members from around the world-different cultures, religions, colors, creeds and countries. I have great respect for our differences, and believe that this diversity is the strength of our society. Today is a day when I can stop and reflect on the value of my friendships and professional partnerships with each of you. We have chosen medicine as a profession, and surgery under the microscope as a tool and technique to perform reconstruction for those in need of our gifts, science and art. Microsurgery is a world sport and we are all on the same team. The challenges and opportunities that reconstructive microsurgery offers us as physicians is unparalleled compared to many other disciplines. «All or none» is one of our mottos. The flap lives or dies. Nothing really in between. What is also true, is that we benefit a great deal sharing our experiences with one another in person. The 2015 meeting in Mumbai will be a time to experience this joy of exchange.

In addition to a spectacular scientific program, the hotel venue in Mumbai (Hyatt) is spectacular in every way, and feeds the «karma» of this potential exchange. How often have we attended a meeting-and sat next to someone that we do not know from another country... only to find out that we as microsurgeons have so much in common. These common bonds include our strong work ethic, our investment into our craft, and our joy at making a difference using microsurgical techniques. Despite the advances in internet technology, and our ability to «Skype», email and teleconference, nothing substitutes for face to face interaction. Furthermore, the country of India has so much to offer-cuisine, culture, history, philosophy and music- to name just a few attractions. Together-we have much work to do.

We are embarking on the next half century of reconstructive microsurgery. Tissue engineering, allotransplantation, genetic modulation, drug discovery and new methods of delivery will no doubt rely on the use of microsurgical techniques. We must continue to build on our foundation and look into the future. Attracting the next generation of microsurgeons is our mission and responsibility. Our goal is to be inclusive-encouraging all that have interest to come to Mumbai, and depart as a valued member of our microsurgical family. Please plan now to set aside March 19—22, 2015 for what I know will be a spectacular celebration of reconstructive microsurgery. Feel free to contact me personally at scott.levin@uphs.upenn.edu for any issues regarding our society or the meeting.

With best wishes for a healthy, prosperous and «thrombosis free» New Year. See you in Mumbai if not before!

Best Regards,
Scott

L. Scott Levin, MD, FACS
WSRM President