CONCLUSION: The majority of patients who suffer traumatic amputations do not present with properly preserved amputated parts, making it difficult for surgeons to offer replantation. Neither interhospital transfer nor emergency medical services transport is predictive of adherence to protocol. With a direct correlation to attempted replantation, proper preservation is a crucial aspect of care. Dissemination of awareness and education to referring facilities may improve outcomes for patients who experience a traumatic amputation of an extremity or digit.

Social Media Use Among Academic Hand Surgeons

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PURPOSE: Social media has revolutionized communication in society and has become an important interface between patients, trainees, and physicians for education, networking, and marketing. A growing number of surgeons are embracing this trend by increasing their social media presence. Many studies have investigated the benefits of a surgeon’s web presence in plastic and aesthetic surgery, but a paucity of data exists in use among academic hand surgeons. The objective of this study was to evaluate social media use in fellowship trained, academic hand surgeons and to investigate differences between orthopaedic and plastic surgery trained hand surgeons.

METHODS: Hand surgery fellowship programs were identified from the ASSH website, and a list of faculty members from each respective program was compiled. A search was performed for faculty members on social media platforms including Facebook, Instagram, Twitter, LinkedIn, and personal websites. The respective accounts and/or personal websites were investigated for any content related to hand surgery; accounts with personal content only were not included. Faculty members were analyzed by sex, board certification status, subspecialty of residency training (plastic surgery versus orthopaedic surgery), years in practice, geographical region (east, west, south, or midwest), and professional presence on a personal website or accessible social media platform. Analysis of variance and student t tests were performed to evaluate the statistical significance ($P = 0.05$) of differences between groups.

RESULTS: A total of 469 academic hand surgeons were included. Among academic hand surgeons in the United States, LinkedIn is the most common platform utilized at 40.3%, followed by Facebook (15.78%), a personal website (13.86%), Twitter (12.37%), and Instagram (4.05%). Plastic hand surgeons are more present on Instagram (8.26% versus 2.59%) and Twitter (19.01% versus 10.06%) ($P = 0.0062837$ and $P = 0.009921$, respectively). Male hand surgeons were more likely than female hand surgeons to use LinkedIn (41.19% versus 34.85%) ($P = 0.044956$). Southern (18.89%) and eastern region (14.36%) surgeons utilized personal websites more than western (6.52%) and midwestern (4.60%) surgeons ($P = 0.0319107$).

CONCLUSION: Despite the widely known use of social media amongst plastic and aesthetic surgeons, this study shows the use of web-based marketing strategies to be quite rare in the academic hand surgery setting. Social media can have a profound impact on medical practices and thus we suggest that academic plastic and orthopaedic hand surgeons throughout the United States should consider having a larger social media presence to expand advertising, improve patient education, and enhance networking within their practices.

Risk Factors for Emergency Department Visits After Upper Extremity Surgery

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PURPOSE: The “global period” after most upper extremity surgeries includes coverage of postoperative visits and routine care with no additional copay or coinsurance for 90 days. Despite this, patients often present to their local emergency department (ED) after surgery with concerns that could be addressed in clinic, resulting in increased costs, overutilization of ED services, and in many systems, negative quality scores for the hospital or surgeon. We examined patient-reported questionnaire data to identify if patient responses indicate risk of subsequent presentation at an emergency department within the 90-day global period after surgery.
Does the Location of Initial Management After Distal Radius Fracture Impact the Ultimate Need for Operative Intervention?

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**BACKGROUND:** Fractures of the radius and/or ulna comprise the largest proportion (44%) of the estimated 1.5 million cases of hand and forearm fractures seen in the United States emergency departments each year.1 Displaced distal radius fractures (DRFs) are often managed with closed reduction and splinting. After initial management of these injuries, patients are referred to tertiary care facilities or specialty groups for continuing care. Failure to obtain a stable, near-anatomic reduction may lead a specialist to recommend and/or perform surgery to re-establish appropriate radiographic relationships. Complication rates associated with nonoperative management have been studied though data on conversion to surgical management are not widely reported.2 Surgery incurs a significant financial and physical cost to the patient and healthcare system. The primary aim of this study was to assess how location and type of facility at which a DRF is initially managed impacts rates of surgical intervention. Specifically, we compared a tertiary care facility, staffed with hand specialists, to referring community institutions where no hand specialists were readily available.

**METHODS:** We performed a retrospective chart review of all patients treated at University of Wisconsin—Hospital and Clinics (UW) for DRFs from January 1, 2018 to December 31, 2018. Patients were placed into one of 2 groups: (1) initial treatment performed at any location within the UW system and (2) initial treatment performed at any location outside of the UW system. We calculated the operative rate for each group. We also analyzed the effect of sex and type of injury on the conversion to surgical management.

**RESULTS:** We identified 1,337 patient encounters associated with a DRF current procedural terminology (CPT) code. Eight hundred twenty-four patients were initially managed at UW Health, whereas 513 patients were initially managed at non-UW facilities. Patients initially managed at UW went on to surgical intervention at a significantly lower rate of 15.0% (n = 124) compared to those patients initially treated outside of UW Health who underwent surgery 26.3% of the time (n = 135) (P < 0.0001). Type of injury was not a predictor of conversion to surgery nor initial presentation to UW. Sex was not a predictor of surgical conversion.

**CONCLUSIONS:** These data suggest that initial management of DRFs at UW Hospital and Clinics significantly decreases the rate of operative reduction and fixation. A decrease in operative intervention reduces both the physical and financial impact of DRFs. This indicates that there may be a need to

**METHODS AND MATERIALS:** All adult patients who underwent surgery at our hand center between January 1, 2018 and August 31, 2019 and consented to data use for research were included. The patients’ medical record numbers were used to identify ED visits anywhere in our health system within 90 days of surgery. Presenting diagnosis was used to identify patients with surgery-related complaints. Preoperative and postoperative questionnaires, including the brief Michigan Hand Questionnaire (bMHQ), the Patient-Reported Outcome Measuring Information System (PROMIS) Upper Extremity (UE) and Pain Interference (PI), pain scores, and postoperative satisfaction scores from the first postoperative visit were collected prospectively. Satisfaction and pain were scored from 0 to 10; 10 is highest satisfaction and highest pain score.

**RESULTS:** Our cohort included 2,056 patients, with 1,033 (50.2%) females and 1,023 (49.8%) males. Sixty-one (3.0%) presented to the ED with hand-related or surgery-related complaints within 90 days after surgery. Preoperative pain scores were higher in the group that presented to the ED compared to those that did not (7 versus 4; P < 0.001), and for every unit increase in preoperative pain, patients were 1.2 times more likely to return to the ED within the global period (P < 0.001) after surgery. Patients who presented to the ED also had preoperative bMHQ scores 14.6 points lower (P < 0.001) and preoperative PROMIS PI scores 5.2 points higher than their counterparts (P = 0.005). Postoperative satisfaction scores were significantly lower in patients who subsequently presented to the ED (8.1 versus 9.1; P < 0.001), whereas other postoperative questionnaire scores were not found to significantly predict likelihood of an ED visit.

**CONCLUSIONS:** Patients who presented to the ED within the global period had significantly higher preoperative pain scores, significantly worse preoperative bMHQ and PROMIS PI scores, and significantly lower postoperative satisfaction scores. These patient-reported scores were associated with an increased likelihood of presenting to the ED for management of a hand or postoperative issue during the global period. These patients should be identified early and counseled on their healthcare options in order to improve value-based care and decrease healthcare utilization.