



SICOT

e-Newsletter



- **Editorial by S. Rajasekaran**

- Snakes and Ladders in Professional Excellence

- **SICOT Events**

- XXVI SICOT Triennial World Congress combined with 46th SBOT Annual Meeting - Rio de Janeiro, Brazil
 - 21st SICOT Trainees Meeting

- **SICOT News**

- SICOT Ortho Excellence Programme (OEP)

- **SICOT Global Network for Electronic Learning - SIGNAL**

- Article of the Month
 - Case of the Month

- **Fellowship News**

- Report of the 'SICOT meets SICOT' Fellowship Programme at the Fondazione IRCCS Policlinico San Matteo, University of Pavia

- **Courses by SICOT Members**

- Assiut Hip Arthroscopy Course

- **Worldwide News**

- Effect of early administration of alendronate after surgery for distal radius fragility fracture on radiological fracture healing time

- **Industry News**

- CeramTec



Editorial by S. Rajasekaran - SICOT Treasurer

Snakes and Ladders in Professional Excellence

This is a talk that was delivered in Agra during IOACON 2013 as the "Kini Memorial Oration", which is by the Immediate Past President of the Indian Orthopaedic Association.



While growing up, many of us would have enjoyed playing the game of snakes and ladders. It is a simple board game, where rolling of the dice moves you along a path that has ladders letting you move up quickly and also snakes waiting to pull you down, sometimes dragging you all the way to the start. But there is a larger picture to decipher. Indian philosophy draws a parallel to our journey towards salvation and excellence in life where virtues are ladders that push us to greater heights while snakes are vices that pull us down. In the original game, the prominent squares of virtues were faith, reliability, generosity, knowledge, asceticism, etc., while the squares of vices were disobedience, vanity, vulgarity, theft, greed, lust, etc. Thus the game was actually a simple way to teach morals in life.

ORIGINAL GAME	
Squares of virtue	Squares of vice
<ul style="list-style-type: none"> • Faith • Reliability • Generosity • Knowledge • Humbleness • Truth • Honesty 	<ul style="list-style-type: none"> • Vanity • Vulgarity • Theft • Lying • Drunkenness • Greed • Lust

Our quest for professional excellence is similar. While thousands of medical professionals start their career with the dream of professional excellence, the numbers, unfortunately, thin out at the top. The snakes distract and charm people away from their goals while the ladders of virtue seem less enticing to climb. This is reflected in the success and failure of several professionals in the medical field.

PROFESSIONAL GAME	
Squares of virtue	Squares of vice
<ul style="list-style-type: none"> • Knowledge • Competence • High aims • Hard work • Passion for work • Compassion to patient 	<ul style="list-style-type: none"> • Poor Training • Impatience for success • Lure of money • Distractions • Early slow down • Professional fatigue • “Easy Going” attitude

Upmost, the two important ladders for any skilled specialist will be professional competence and excellent surgical skills. These are essential to catapult anyone beyond competition and make him stand out amongst the crowd. While professional competence is important in any job, it is more so in surgery, as at the receiving end of the scalpel is a patient who is a husband, mother, wife, son or father to someone else and on whose good health an entire family depends on. It is vital that we avoid medical mistakes which still hover on us as one of the important causes of death in patients entering hospitals. Building a culture of safety in your work pattern is again a strong ladder that can propel you up in the path of success.

Dedicated training with a great mentor is an important ladder that can provide experience and build a strong foundation that no technology or gadget can provide. It is wise not to just rely on technology and remember the adage '**A fool with a new tool is still a fool**'. Avoiding cutting-edge technologies and new devices that have no safety record but great potential for media advertisement is crucial. My mentor, Prof T.K. Shanmugasundaram, used to tell us, 'If you want to be a cutting-edge surgeon, stay with the times. But your patient may suffer often. But **if you want to be a safe surgeon, be five years behind the times**'.

As we progress in the career, **one has to understand that no success transpires overnight**. 'Impatience for success' is a tricky snake that can cause wise people to do many foolish things. Mr Narayanamurthy of Infosys, on being asked how they became an overnight success, replied: 'By working hard for 25 years'. Impatience can draw a surgeon towards unwanted procedures, loose indications, unethical work practices and dicey financial partnerships. It is important to understand the difference between leap frogging towards success and professional shortcuts as the former is the result of knowledge and hard work and the latter is the result of temptation to easy success. Low goals, easy contentment and

the tendency to settle for less when more is possible are a few other snakes in the mid-professional career which swallow most of the professionals.

Rather than looking at performance alone, one must also look at the 'performance gap' - that appalling space that divides what we are doing and what we are capable of. Frequently there is a huge gap. One has to strive for the ladders of high aims and hard work at every stage of one's career. No achievement is possible without a high dream. Steve Jobs did not aim for just another improved phone on the market but that his 'products must put a ding in the universe' and the rest is history. However, it is hard work that makes a dream a possibility. The former President of India, A.P.J. Abdul Kalam, rightly mentioned: **'Dreams are not what you see in sleep; they are which don't let you sleep'**. 'Passion for work', 'purpose' and attitude can fuel hard work in the right direction.

With success comes a few vices of 'celebrating success too early'; 'succumbing to early slow down' and 'distractions'. One also has to overcome the snake of 'professional fatigue', which happens due to monotony of work. Individuals and institutions need to reinvent themselves and do new things at least every five years. Remember Steve Jobs question: 'When was the last time that you did something for the first time?'

The next important ladder is the habit of 'keeping the main thing in life as the main thing'. Losing focus and getting distracted by other businesses and ventures can derail a young surgeon from professional excellence. Money should be the byproduct of professional achievements and not the main quest. Sachin Tendulkar, Indian cricketer, was an example of the singleness of purpose when, after 20 years of cricket history, he said: 'I only think of playing good cricket, nothing else. The hunger for runs is the same today as when I started'. Similar commitment was echoed in the words of Joe DiMaggio, the NY Yankees striker: 'I cannot relax in any game. There is always some kid who may be seeing me for the first time, I owe him my best'. People with such attitude and commitments have never been stood second to anyone.

The last and important ladder is the process of transformation of an individual to an institution and building an excellent team. The need for a committed team is echoed in the **Chinese proverb, 'if you want to walk fast, walk alone; if you want to walk far, walk together'**. The power of a committed team and the collective wisdom of a group are incomparable to even the best of an individual.

Lastly, from the beginning to the end of the career, there are a few pillars that provide strength, support and fuel growth. They are the love and support from the family, good friends, and probably also religion and faith. No professional career can be without its ups and downs. It is the strength of the family, the support of true friends and advice from colleagues that will help one to sail to the top. They are the true lifeboats in one's professional career.

The full talk is available on YouTube with the keywords - Dr S Rajasekaran, Snakes and Ladders and Kini Memorial Oration.

SICOT Events

XXVI SICOT Triennial World Congress combined with 46th SBOT Annual Meeting Rio de Janeiro TWC 2014 19-22 November 2014 * Rio de Janeiro, Brazil



- **Registration**

Congress registration is open [here](#) for all participants not residing in Brazil. Participants residing in Brazil should register [here](#).

- **Awards**

Click [here](#) to find out more about the awards which are granted to young surgeons to help them attend the Congress.

- **Accommodation & Tours**

Don't miss out on exclusive hotel and tour offers in Rio de Janeiro! Click [here](#) for more information.

- **Exhibition & Sponsorship**

Don't miss this unique opportunity to promote your products and services to leading international orthopaedic surgeons, traumatologists and specialists in related fields. [Read more...](#)

21st SICOT Trainees Meeting 1-2 June 2014 * London, United Kingdom



- **Registration**

Registration is open [here](#)!

- **Awards**

SICOT Trainee Prizes for Best Oral Presentations will be awarded toward travel expenses to attend the next SICOT Triennial World Congress in Rio de Janeiro, as follows:

1st Prize: £1000

2nd Prize: £600

3rd Prize: £400

SICOT News

- **SICOT Ortho Excellence Programme (OEP)**

This programme has been organised under the aegis of SICOT Education. As conceptualized, a well-known international SICOT surgeon presents a webinar on the second Friday of every month. This is open to orthopaedic surgeons in India and other parts of the world. In India it is targeted to 5,000 surgeons. For more details please see the OEP website at www.sicotoep.com or the [SICOT website](#).

SICOT Global Network for Electronic Learning - SIGNEL

Article of the Month

March 2014

Progress in musculoskeletal oncology from 1922-2012

Rainer I. Kotz

Since 1922 surgical approaches toward limb salvage in bone and soft tissue tumours have been documented. There is the famous "Umkipplastik" of Sauerbruch, the "Tikhoff-Linberg" inter-scapulo-thoracic resection or in 1943 a metallic tumour prosthesis for the hip joint in the United States (Moore, Bohlman). Since 1960 acrylic prostheses and metallic prostheses with bone cement have been in use. Cement-free implants and the first modular ceramic prostheses were implanted in the 1970s in Vienna. At the same time successful chemotherapy in bone sarcomas was introduced by Gerald Rosen and Norman Jaffe. This was mainly the decade of custom-made prostheses. In the 1980s modular tumour prostheses with cone connection to be adopted to the needs of the patient were built intra-operatively. Since 1981 biannual international meetings (ISOLS) have pushed forward the field of bone tumour treatment to allow also tumour resection in wide borders for spine and pelvic tumours. New hope for resistant tumours could be monoclonal antibodies or even dendritic cell therapy.

International Orthopaedics (SICOT)

DOI 10.1007/s00264-014-2315-0

Case of the Month

March 2014

Author: Mahmoud Abdel Kerim - Cairo, Egypt

Thirteen-year-old male patient presented with right groin pain, inability to weight bear on the right side. History revealed that he had left slipped upper femoral epiphysis 16 months earlier, which was managed by single in situ screw fixation. The patient had evidence of endocrinopathy with hypogonadism, so the contralateral (right) hip was simultaneously prophylactically pinned with single screw.

The patient had bilateral removal of the screws 12 months postoperatively. Four months later, he started to have pain in the right hip especially on walking associated with limping on the right side. He presented in the outpatient clinic with increasing right hip pain and inability to weight bear. The right lower limb was shorter than the left with limb length discrepancy of about 1.5 cm. Both lower limbs were held in external rotation. The right side had about 60 degrees of external rotation, which he developed recently after the removal of the screw whereas the left side had residual 70 degrees; his mother noticed this after the index surgery of in situ fixation of the left hip. X-rays revealed slipped upper femoral epiphysis on the right side (which was fixed prophylactically) of moderate degree. MRI revealed viable femoral head.



Figure 1 (a & b): Preoperative X-rays showing slipped upper femoral epiphysis on the right side after removal of the screws.

What treatment would you suggest?

[Click here to read more...](#)

[Back to previous section](#)

After thorough counselling with the patient's family and a properly informed consenting process, the patient was operated upon and had surgical hip dislocation, modified Dunn's osteotomy and anatomic reduction and fixation of the slipped right upper femoral epiphysis as described by Ganz et al (1). The patient has a very satisfactory functional outcome.



Figure 2 (a & b): Postoperative X-ray after surgical hip dislocation, modified Dunn's osteotomy and anatomic reduction and fixation of the slipped epiphysis.

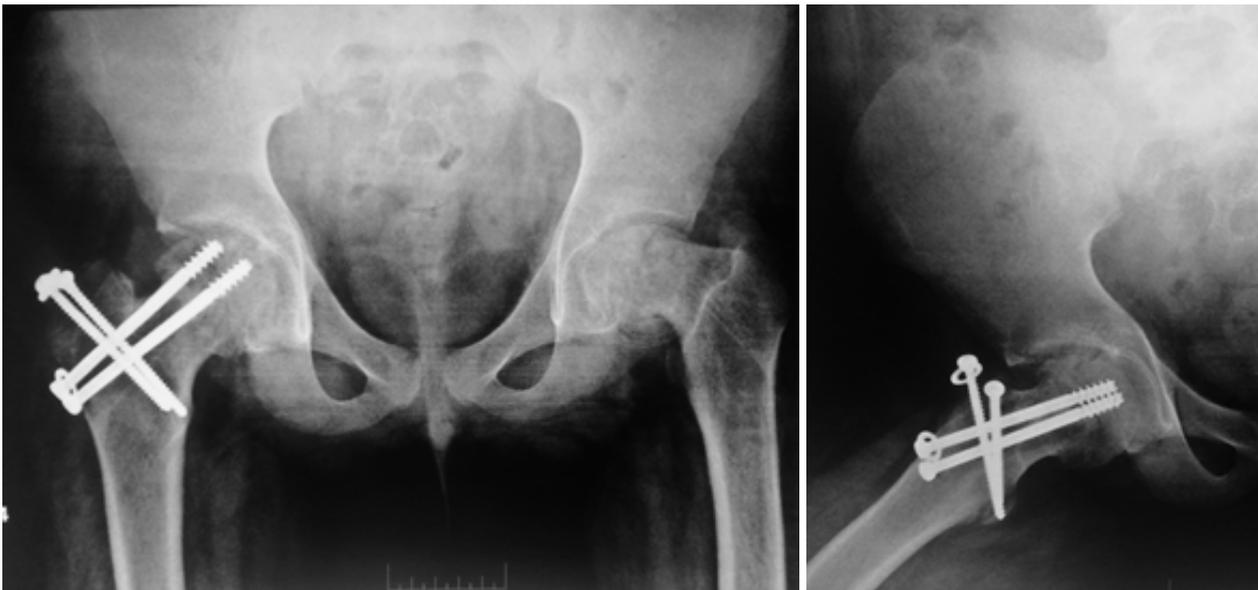


Figure 3 (a & b): 12 months' follow-up X-rays



Figure 4: Clinical photograph showing restoration of the neutral rotational alignment on the right side which was operated upon compared to the left side.

Discussion:

Slipped capital femoral epiphysis (SCFE) is the most common hip disorder in adolescents with an incidence from one to seven per 100,000 (2). The goal of surgical treatment is to prevent further slipping and to induce physal closure (3). The fixation must be secured until the growth plate closes to prevent further progression of the disease. Whether or not the material is subsequently removed remains controversial. The results of a survey of the membership of the British Society of Children's Orthopaedic Surgery and the *Werkgroep Kinder Orthopaedie* showed that the more experienced surgeons were less likely to remove the metalwork (4). In this case, we report the occurrence of slipping of the upper femoral epiphysis, which was in situ fixed prophylactically, following removal of the screws 12 months postoperatively. It could be advisable not to remove the fixation screws of the slipped upper femoral epiphysis until after closure of the growth plate especially in patients with underlying endocrinopathy.

References and further reading:

1. Capital realignment for moderate and severe SCFE using a modified Dunn procedure. Ziebarth K, Zilkens C, Spencer S, Leunig M, Ganz R, Kim YJ. *Clin Orthop Relat Res.* 2009 Mar;467(3):704-16.
2. Loder RT, Aronsson DD, Weinstein SL, Breur GJ, Ganz R, Leunig M: Slipped capital femoral epiphysis. *Instr*

Course Lect 2008, 57:473–498.

3. Lehman WB, Menche D, Grant A, Norman A, Pugh J. The problem of evaluating in situ pinning of slipped capital femoral epiphysis: an experimental model and a review of 63 consecutive cases. *J Pediatr Orthop* 1984;4: 297-303.
4. Witbreuk M, Besselaar P, Eastwood D: Current practice in the management of acute/unstable slipped capital femoral epiphyses in the United Kingdom and the Netherlands: results of a survey of the membership of the British Society of Children's Orthopaedic Surgery and the Werkgroep Kinder Orthopaedie. *J Pediatr Orthop B* 2007, 16(2): 79–83.

Fellowship News



Report of the 'SICOT meets SICOT' Fellowship Programme at the Fondazione IRCCS Policlinico San Matteo, University of Pavia

Karampinas Panagiotis

SICOT Associate Member - Athens, Greece

It is with great pleasure that I report my experience as a Hip and Knee Reconstruction Fellow at IRCCS Policlinico San Matteo, University of Pavia, from 3 November to 1 December 2013.

I received with great pleasure the notification that I had been accepted for the 2013 'SICOT meets SICOT' Visiting Fellowship. I reached Pavia on 3 November 2013, after a quick flight from Athens to Milan, and I moved into the accommodation on the University campus which was arranged for me by the Orthopaedic Department. At this point I would like to thank Dr Stefano Marco Paolo Rossi. I deeply thank him for the warm welcome and for providing me with all the necessary directions for my stay. The next day I met Prof F. Benazzo and he accepted me in his team with great pleasure and enthusiasm. He was very friendly and I loved working and following him in every activity in the department.

Every working day started with a morning meeting, where details about patients admitted from the emergency department the day before, patients' nurses in the department, and the operating theatre schedule of the day were discussed in the presence of all consultants and ward nurses. I started attending the theatres with Prof F. Benazzo immediately. I had an opportunity to scrub-in as assistant in most of his cases and I was allowed to actively participate in each surgery. I also had the fortune to be present during the visit of different surgical teams from around the world, such as Japan and the United States, and hear him giving guidelines and technique tips on THA and TKA Revisions to very experienced surgeons.

Together with Prof F. Benazzo, there are 3 consultants whom I worked with in the Hip and Knee unit, Dr G. Zanone, Dr C. Pavesi and Dr Stefano M.P. Rossi. I was fortunate enough to operate with each one of them. The hospital, being a referral care centre, deals with a wide range of Hip, Knee and Sports Medicine disorders. The volume of cases operated here was really great. During my four-week stay, I participated in a total of 58 cases and was mainly interested in Primary Total Knee (TKA) and Total Hip Arthroplasty (THA), Revision TKA and THA, Unicompartamental Knee Replacement and Anterior Cruciate Ligament Reconstruction. I could assist in a wide range of these cases and accumulate great experience by the methods and techniques applied. I particularly enjoyed the teamwork of the operating theatre members and I was fascinated by the systematic preoperative and intraoperative planning of the operations. I also followed up the patients in the wards and in the outpatient visits, supervised and taught by Prof F. Benazzo. The nursing and paramedical staff were committed and contributed significantly to the care of the patients. It was a pleasure working with Prof F. Benazzo and he made every challenging surgery look seemingly simple. I was truly impressed with his technique and surgical outcome. Operating with him was an enjoyable experience, as he takes a keen interest in explaining every step of the surgery and taught me some great tricks.

I also assisted a number of cases with Dr G. Zanone and learned from him during some interesting Anterior Cruciate Ligament Reconstructions. He taught me some of his tricks and I loved his techniques, specifically the Double-Bundle Medial Patellofemoral Ligament Reconstruction with a Single Patellar Tunnel.

Finally, I wish to express my gratitude and appreciation for the hospitality, extended cooperation, friendship and constant support of Prof F. Benazzo during my stay. I will really miss the wonderful time I spent in Pavia. Overall, it was a great experience and I would thoroughly recommend this fellowship to my colleagues. I sincerely thank SICOT for providing me with this great opportunity.



Courses by SICOT Members

- **Assiut Hip Arthroscopy Course**

The Assiut Hip Arthroscopy Course will take place on 28-29 May 2014 at Assiut University Hospital, a SICOT Education Centre, in Egypt. The aim of this course is to introduce surgeons planning to start hip arthroscopy to:

- Indications;
- Diagnosis Clinical/Radiological;
- Techniques: portals, access to surgery;
- Decision making.

The course is targeted to surgeons with good knee and shoulder arthroscopic skills wishing to start or already performing hip arthroscopy or hip arthroplasty surgeons with knee arthroscopy skills. Please book early as places are limited. [Read more...](#)

Worldwide News

Effect of early administration of alendronate after surgery for distal radius fragility fracture on radiological fracture healing time

S. Uchiyama, T. Itsubo, K. Nakamura, Y. Fujinaga, N. Sato, T. Imaeda, M. Kadoya, H. Kato
Bone Joint Journal 2013;95-B:1544–50.

Abstract

Background: This multicentre prospective clinical trial aimed to determine whether early administration of alendronate (ALN) delays fracture healing after surgical treatment of fractures of the distal radius.

Patients and Method: The study population comprised 80 patients (four men and 76 women) with a mean age of 70 years (52 to 86) with acute fragility fractures of the distal radius requiring open reduction and internal fixation with a volar locking plate and screws. Two groups of 40 patients each were randomly allocated either to receive once weekly oral ALN administration (35 mg) within a few days after surgery and continued for six months, or oral ALN administration delayed until four months after surgery. Postero-anterior and lateral radiographs of the affected wrist were taken monthly for six months after surgery.

Results: No differences between groups were observed with regard to gender ($p = 1.0$), age ($p = 0.916$), fracture classification ($p = 0.274$) or bone mineral density measured at the spine ($p = 0.714$). Three independent assessors assessed the radiographs. There were no significant differences in the mean time to complete cortical bridging observed between the ALN group (3.5 months (SE 0.16)) and the no-ALN group (3.1 months (SE 0.15)) ($p = 0.068$). All the fractures healed in both groups by the last follow-up. Improvement of the Quick Disabilities of the Arm, Shoulder and Hand (QuickDASH) score, grip strength, wrist range of movement, and tenderness over the fracture site did not differ between the groups over the six-month period.

Summary: Based on our results, early administration of ALN after surgery for distal radius fracture did not appear to delay fracture-healing times either radiologically or clinically.

Comment by Syah Bahari

This is a very well-designed randomised control study that highlighted the issue on optimising the care for osteoporotic related distal radius fractures specifically and osteoporotic related fractures generally.

The authors acknowledged the concern of starting antiresorptive therapy for the patient right after the fracture due to the effect of antiresorptive medication on bone remodelling. Although the initiation of antiresorptive therapy after osteoporotic vertebral and hip fracture has been better received, the use of antiresorptive therapy for osteoporotic distal radius fractures is still not widely accepted. I agree that the distal radius fracture is usually the first fragility fracture sustained by osteoporotic patients, thus early intervention will likely prevent future fragility fractures.

The take home message from this study was that the primary outcome of cortical bridging across the fracture site was not significant between the treated group and the control. The secondary outcome such as functional outcome I believe is related to the use of the locking plate for fracture fixation. This also begs the question on whether the conclusion from this study can be used for conservative treatment or closed reduction and percutaneous wire fixation of distal radius fractures.

Another issue is that the dose of alendronate used in this study was 35mg weekly, instead of the recommended dose of 70mg weekly. The authors did acknowledge this in their discussion. However, the question is whether the recommended dose of 70mg weekly may affect bone remodelling?

Overall, I think this study provides satisfactory evidence to support early initiation of antiresorptive therapy for osteoporotic distal radius fracture.

Industry News

- CeramTec



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inside

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