



Issue No. 56 - May 2013

SICOT

e-Newsletter



- **Editorial by Maurice Hinsenkamp**
 - SICOT welcomes the SAARC and APOA member countries as its 2013 Friendship Nations
- **SICOT Events**
 - 34th SICOT Orthopaedic World Congress - Hyderabad, India
- **Meetings by SICOT Members**
 - Course on "Fractures of the Upper End of the Femur"
- **Articles by SICOT Members**
 - The Activities of AMFA (Association Médicale Franco Asiatique) in 2012
- **SICOT Global Network for Electronic Learning - SIGNAL**
 - Article of the Month
 - Case of the Month
- **Fellowship News**
 - Report of Training Fellowship in Arthroplasty at Ganga Medical Centre & Hospitals
- **Expert Corner**
 - Surgical Management of Bankart Operation
- **History of Orthopaedics**
 - Hippocratic Oath... A pledge, The journey, Our destiny (Part 2)
- **Worldwide News**
 - Evidence Based Orthopaedics
- **Industry News**
 - Normed

Editorial by Maurice Hinsenkamp - *SICOT President*



SICOT welcomes the SAARC and APOA member countries as its 2013 Friendship Nations

In the past few years SICOT has welcomed India, Japan, China, Russian-speaking countries, and the Pan Arab Orthopaedic Association member countries as its Friendship Nations. This partnership honours specific nations at our annual meetings, and a number of privileges are arranged for new SICOT members and Congress participants from the selected Nations. This year, the SICOT Friendship Nations are the SAARC member countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka) and the APOA (Asia Pacific Orthopaedic Association) member countries (Australia, China, Hong Kong, Indonesia, Japan, Kazakhstan, Korea, Laos, Malaysia, New Zealand, Philippines, Singapore, Taiwan, and Thailand). As in previous years, we are offering special advantages to those residing in our Friendship Nations, including discounted dues for new members in their first year of membership. If you reside in one of these countries, do not miss this opportunity and join us by applying for membership now via the [SICOT website](#).

The organisation of the 34th SICOT Orthopaedic World Congress in Hyderabad, India, is progressing well. The final result will confirm the expansion of the SICOT meetings, in terms of scientific excellence and attendance, which has been observed in the last few years. A month ago, the CSAC made the last selection for oral presentations, oral communications, and e-posters. The presenting authors have received the proposed schedule for their presentation and will have to confirm their participation by 31 May. This is the right time to remind you of the benefits of being a SICOT member, and not only if you live in a Friendship Nation. In addition to the scientific information updating your orthopaedic knowledge that SICOT membership provides, it also offers you the possibility to register for the Congress in Hyderabad at a reduced rate.

The whole international community of SICOT is enthusiastic about inviting the neighbouring countries of India to share their high-quality scientific contributions and to enjoy the rich and diversified cultural events offered by magnificent India.

Looking forward to seeing you all in Hyderabad.

SICOT Events

34th SICOT Orthopaedic World Congress (Hyderabad OWC 2013) 17-19 October 2013 * Hyderabad, India

- **Registration**

Online congress registration is open [here](#)! **Presenting authors must register before 31 May 2013.**

- **Scientific Programme**

SICOT is pleased to announce that José Sérgio Franco, Dror Paley, Shanmuganathan Rajasekaran, and Steffen Ruchholtz will be delivering plenary lectures at the Hyderabad meeting. [Read more...](#)

- **Diploma Examination**

Registration for the eleventh SICOT Diploma Examination in Hyderabad is now closed. Candidates have been notified of their selection or non-selection. [Read more...](#)

- **Awards**

Click [here](#) to find out more about the awards which are available to presenting authors at the Congress.

- **Social Programme**

Don't miss the entertaining social programme and the chance to experience the rich culture of India.[Read more...](#)

- **Accommodation & Tours**

Hotel booking for SICOT 2013 participants at Hyderabad is on! We have secured attractive discounted rates for a number of rooms in different categories of hotels close to the Hyderabad International Convention Centre. Shuttle transportation will be provided between the Congress venue and the official hotels at fixed times in the morning and evening for only those delegates who have booked through the official website: [Online Hotel Accommodation Booking](#)

- **Exhibition & Sponsorship**

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

Meetings by SICOT Members

- **Course on "Fractures of the Upper End of the Femur"**

The Egyptian Pelvis & Hip Society and the SICOT Egypt section invite you for a day course on "Fractures of the Upper End of the Femur" on Thursday, 4 July 2013 at the Medical Military Academy in Cairo, Egypt. This course will include three internal fixation hands-on workshops and instructional lectures delivered by distinguished faculty. For more information, please click [here](#).

Articles by SICOT Members



The Activities of AMFA (*Association Médicale Franco Asiatique*) in 2012

Geoffrey Walker

SICOT Emeritus Member - London, United Kingdom

This short summary in English of last year's annual report is really a tribute to Prof Alain Patel, the Founder and President of AMFA, for his enormous efforts to improve orthopaedic and other medical services in Myanmar. In 2012, in spite of the difficult financial climate, AMFA received donations in cash of EUR 342,983 and of EUR 826,150 as materials, transport, activities of volunteers and support from various other charities. The *Assistance Publique - Hôpitaux de Paris* (AP-HP) has always provided considerable support with assistance from Directors, Engineers and Senior Nurses. Experienced technicians use their holidays to train Burmese colleagues how to install and repair equipment.

Another project has been to rebuild, modernise, and equip the old British-built hospital in Myeik and this has been done with the assistance of the Rainbow Bridge Foundation. The facilities for the delivery of babies and the care of children requiring admission have been greatly increased. In addition about 34% of the 150,000 population who inhabit 200 of the 800 Myeik islands are now covered for their basic health needs by staff largely trained and supported by AMFA who have also constructed 14 dispensaries in the islands. All medicines are provided free of charge.

In Mandalay the orthopaedic hospital fully equipped by AMFA (at a cost of EUR 750,000) is running very well with an average of 16 operations being performed each day. A specialist surgical training unit has been established and has resulted in an increase in the volume of cardiac surgery performed. This has been made possible by the help of many visiting specialists who have also been able to train local doctors and other staff. The Albert Schweitzer hospital (in the Netherlands) has sent visiting anaesthetists to teach and to practise modern techniques.

In Yangon two French teams of orthopaedic surgeons and anaesthetists have allowed the surgical correction of scoliosis (supported by Medtronic and International SOS) and several Burmese surgeons are learning the necessary complicated techniques.

Adequate sterility is a problem throughout Myanmar with rats, insects, and humidity everywhere. A unique 'workshop school' that had been established a while ago recently required major restoration on account of these problems. Apparently, rats had chewed through some of the electric cables and there were other grave deficiencies. This recent repair work was done with the aid of visiting technicians and other specialists supported by International SOS. Air France provided flights for some of these personnel.

It is obvious that AMFA depends on the service - very largely voluntary - of a great number of individuals and in this short summary I am only going to mention one - apart from Prof Patel. This is Po Po Aung, known as 'Pole', who is considered to be the soul of AMFA in Myanmar. She remains in constant touch with the Professor and manages just about everything, including liaison with the Ministry of Health, the financial accounts, shipping of materials and supplies, care of the poor and the general organisation of AMFA's activities everywhere in Myanmar.

These selected and brief reports are only a small part of AMFA's activity in Myanmar. They are almost entirely the result of continued stimulation by the very effective and diplomatic techniques used so well by Prof Patel. Of course he has received great assistance by colleagues both from France and from other relatively rich countries as well as by local individuals. He manages to extract support from charities and private donors and from just about everyone that he meets. On 1 April 2013, Professor Patel was further honoured by the French President with promotion to the rank of '*Commandeur de la légion d'honneur*'.

Copies of the full report (in French) of the 2012 activities of AMFA may be obtained by sending an e-mail to Prof Patel at AMFA headquarters in Paris: amfafrance@netcourrier.com. The relevant website is: amfa-france.org

SICOT Global Network for Electronic Learning - SIGNAL

Article of the Month

May 2013

Indications for and results of arthroscopy in the arthritic knee: a European survey

Hermann Otto Mayr, Matthias Rueschenschmidt, Romain Seil, David Dejour, Anke Bernstein, Norbert Suedkamp & Amelie Stoehr

Purpose The place of arthroscopic treatment in osteoarthritis of the knee has generated much controversy. A survey was initiated to collect the opinion of experienced surgeons.

Methods Of the 211 surgeons interviewed, 170 (80.6%) replied to the electronic questionnaire. Respondents had at least ten years experience in arthroscopy and currently perform more than 100 arthroscopies per year. Various indications and treatment modalities for arthroscopy in osteoarthritis of the knee had to be evaluated on a scale from "excellent" to "no indication".

Results The respondents generally believe that an improvement is more likely in low-grade osteoarthritis ($p < 0.001$) and in neutral leg axis ($p < 0.001$). The outcome was rated better if symptoms had persisted for less than six months ($p < 0.001$) and for patients that were younger than 60 years ($p < 0.001$). Partial meniscectomy and notchplasty in cases of extension deficit were considered as successful treatment options. Debridement was an accepted indication, with an outcome mainly rated as fair. A majority saw no indication for joint lavage, arthroscopic treatment of arthrofibrosis and removal of osteophytes. The outcome appears to be poor if a bone oedema is diagnosed on magnetic resonance imaging prior to arthroscopy. Only 55.9% of respondents were comfortable with the current definition of osteoarthritis.

Conclusions Experienced surgeons all over Europe believe arthroscopy in osteoarthritis is suitable. The major task for surgeons is to select the right patients who are likely to benefit from this intervention.

International Orthopaedics (SICOT)

DOI 10.1007/s00264-013-1896-3

SICOT Global Network for Electronic Learning - SIGNAL

Case of the Month

May 2013

Author: Maher Halawa - Egypt (maherhalawa1@me.com)

Neuropathic pain after total hip arthroplasty (THA)

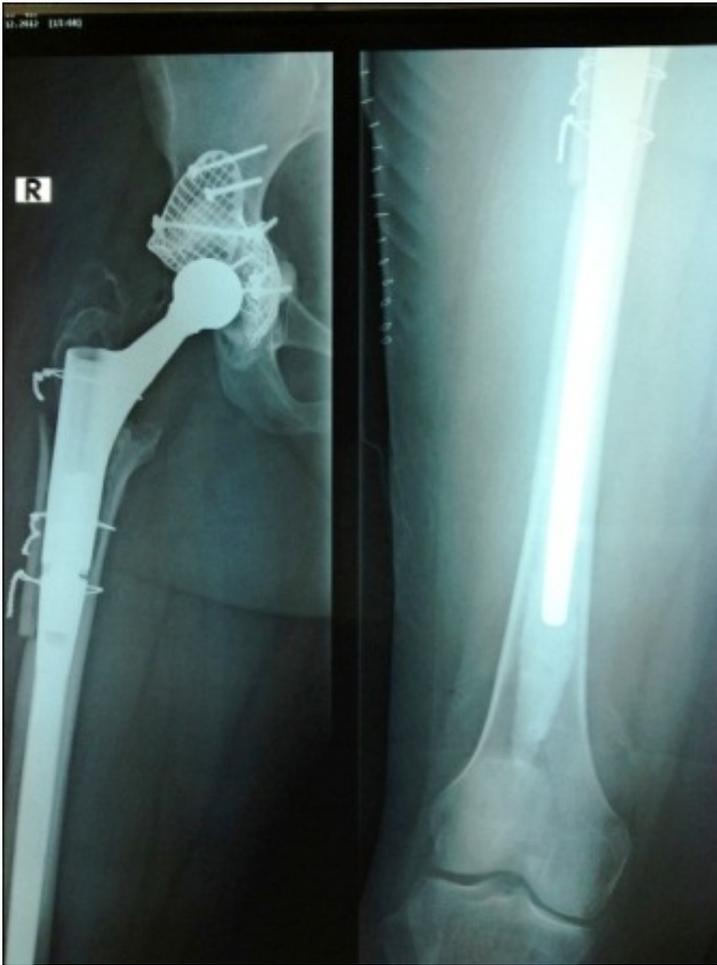
A lady presented in 2012 with right hip pain after a THA 16 years previously. Currently the pain caused her to use two elbow crutches, with inability to fully weight bear on RT leg. X-rays showed polyethylene wear with wear granuloma in the back of the metal shell of the cup and loose zones around femoral component.



X-ray before the operation

In October 2012, she had a revision surgery using a rim mesh, impaction grafting of the acetabulum and a cemented long stem through an extended trochanteric osteotomy.

Following surgery, pain was controlled by epidural analgesia. She suffered complete sciatic nerve palsy with paraesthesia in the foot and lower leg. There was no limb length discrepancy nor any wound complications. After cessation of the epidural analgesia, she suffered from severe neuralgic pain that failed to be controlled by pregabalin and all types of analgesia, even a sympathetic block.



Post-operative radiograph

Six weeks after surgery she regained plantar flexion of the toe and some power of ankle flexion but the neuralgic pain remained quite bad. She was kept on pregabalin, tramadol and panadol.

What do you think of the cause and management of such a condition?

1. Traction from the revision surgery
2. Misplaced retractors during surgery – injuring the Sciatic nerve
3. Protruding hardware / screws

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

[Back to previous section](#)

How would you best approach Sciatic nerve palsy P.O.?:

1. Wait and see >3 months
2. Early exploration of the sciatic nerve
3. Electrical stimulation and nerve blocks

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

[Back to previous section](#)

Discussion:

Sciatic nerve palsy after total hip replacement (THR) is an uncommon complication. Its incidence after primary THR has been reported between 0.17% (1) and 1% (2). The incidence after revision THR has been reported to be as high as 7.6%. These figures are in contrast to electromyographic (EMG) studies, which indicate that subclinical nerve injury may occur in up to 70% of cases (3).

In January 2013, the BJJ published an article on “exploration and neurolysis for the treatment of neuropathic pain in patients with sciatic nerve palsy after total hip replacement” (4). The author treated 56 patients. He showed that the improvement between the pre- and post-neurolysis VAS scores was significant ($p < 0.001$). Only ten patients (18%) reported no improvement and none had an increase in pain after neurolysis. He concluded that his findings supported the hypothesis that sciatic nerve neurolysis may improve neuropathic pain in patients with sciatic nerve palsy after THR.

Our patient was counseled regarding this procedure. On exploration, there was one screw that was used to fix the mesh (it was done from the direct lateral approach), which was tethering the sciatic nerve. The nerve was dissected to the greater sciatic notch through a posterior exposure.

The neuralgic pain improved soon after surgery and the weakness of the foot started to improve. The sciatic nerve eventually recovered completely and now she walks without any foot splint and has no radicular pain.

References:

1. Farrell CM, Springer BD, Haidukewych GJ, Morrey BF. Motor nerve palsy following primary total hip arthroplasty. *J Bone Joint Surg [Am]* 2005;87-A:2619–2625.
2. Schmalzried TP, Amstutz HC, Dorey FJ. Nerve palsy associated with total hip replacement: risk factors and prognosis. *J Bone Joint Surg [Am]* 1991;73-A:1074–1080.
3. Yacoubian SV, Sah AP, Estok DM 2nd. Incidence of sciatic nerve palsy after revision hip arthroplasty through a posterior approach. *J Arthroplasty* 2010;25:31–34.
4. Kyriacou S, Pastides PS, Singh VK, Jeyaseelan L, Sinisi M, Fox M. Exploration and neurolysis for the treatment of neuropathic pain in patients with a sciatic nerve palsy after total hip replacement. *Bone Joint J.* 2013 Jan;95-B(1):20-2.

Fellowship News

Report of Training Fellowship in Arthroplasty at Ganga Medical Centre & Hospitals

Wakeel Olaide Lawal - Lagos, Nigeria

It was a dream come true when Prof Jochen Eulert, SICOT Secretary General, informed me that a 3-month training fellowship in arthroplasty had been approved for me at [Ganga Medical Centre & Hospitals](#), Coimbatore, India. It was a difficult decision for me because I had to resign from my 6-month fellowship job, which had been offered to me by my training institution after passing the fellowship examination of the West African College of Surgeons, and lose 6 months of salary. However, this great opportunity to improve my skills and knowledge in arthroplasty was enough consolation.



Ganga Hospital is a 420-bed hospital with a state of the art facility. It provides care in various subspecialties of Orthopaedics, Plastic and Reconstruction Surgeries. The Hospital is situated in the heart of Coimbatore, a city popularly referred to as Medical City because of the large number of hospitals in the city. The Orthopaedics Department has 5 theatre suites that deal with arthroplasty, spine, arthroscopy, and paediatric cases and a separate 5 theatre suites for trauma. The arthroplasty units perform an average of 8 to 12 cases per day and this is more than enough for adequate exposure and training.

I arrived at Coimbatore on 30 August 2012 to start the training in September and to my surprise a car was already waiting for me at the airport to take me to my lodge. My accommodation was at M.K. Homes, which is about a 10-minute drive to the hospital. It is a privately owned lodge and I was paying per month 6,000 rupees for rent, 300 rupees for electricity, and 600 rupees for transport.

On 3 September, I met Prof Shanmuganathan Rajasekaran during a clinical teaching. He introduced me to other fellows who were with him for the breakfast clinical teaching. This prepared me quickly for training as I listened to the wealth of knowledge coming from him. I was happy I had taken the decision to come to this hospital for training. He introduced me to Dr Dhanasekaran, a consultant arthroplasty and trauma surgeon in the hospital, whose unit I was attached to. He took me around the hospital to familiarise myself and I felt at home instantly.

I started the training on the same day. I worked directly with Prof Rajasekaran, Dr Dhanasekaran, and occasionally with Dr Rajkumar, who is also a consultant arthroplasty and trauma surgeon in the hospital. I attended 6 day theatre sessions in about a week, out of which one was a trauma operating session. Each unit roster has an average of 6 arthroplasty cases per day which includes various complex primary total knee replacements, total hip replacements and revisions. I was directly involved in the management of cases, and I scrubbed for about 3-4 cases per theatre session and for more than 70 cases throughout the period of the fellowship.



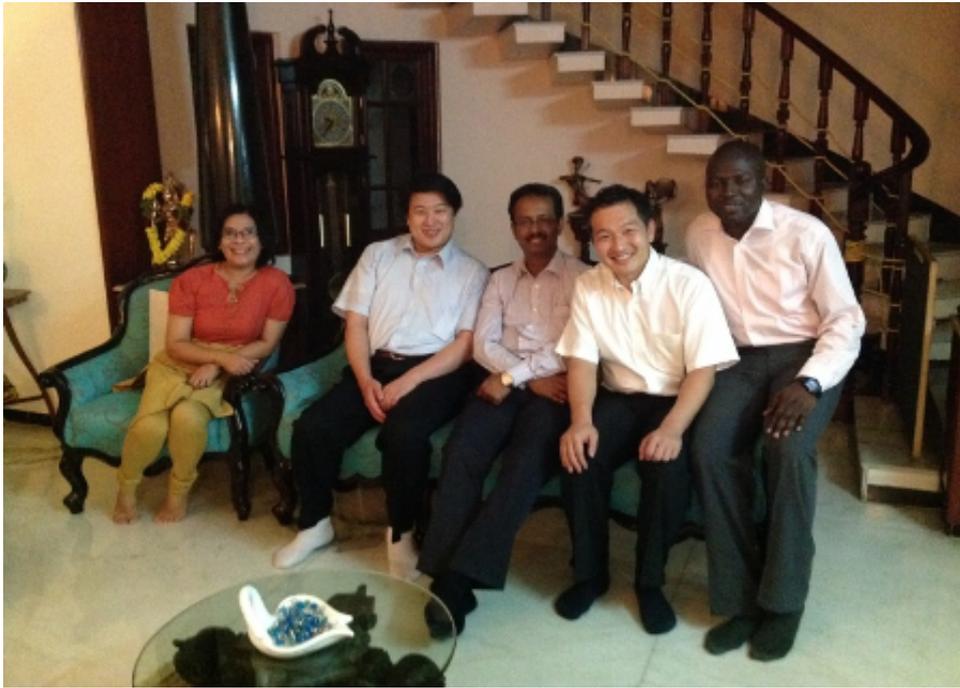
While working with Prof Rajasekaran, I learnt many tips on the technical aspect of arthroplasty which comes from experience. I also had the opportunity to assist him in some complex total hip and knee replacements as well as cases of revision surgery. He made sure I was always present for his cases and this assisted me tremendously because of the knowledge he shared with me whenever I worked with him.

Another training programme was a demonstration with hip and knee models which was coordinated by Dr Rajkumar. This gave me a clear picture of what to expect in the course of the surgery.



At GMCH, my supervising consultant ensured that I had the same opportunities as other arthroplasty fellows, irrespective of where I was coming from. I scrubbed for many replacements, including computer navigated total knee replacement, and attended follow-up clinics. I also observed a variety of trauma cases especially management of fractures around the hip, ankle, and proximal and distal humerus. I particularly enjoyed routine operating table discussions as well as discussions of cases in the clinic.

Coming to India (Ganga) has afforded me the opportunity of taking an ATLS Course. I also attended 2 workshops: one on complex primary knee replacement at Kovai Medical Centre and Hospital (KMCH) and another on the management of complex limb injuries at GMCH.



Sunday was a resting day for me during the training and I used this to get acquainted with my environment and visit important places in Coimbatore.

The surgical experience that I gained at the GMCH is incomparable to what I had in my primary training centre. I am really happy that I had my training in this hospital considering the volume of cases I was exposed to within this short period of time. I do not think I could have gotten this anywhere else.

Finally, I wish to express my gratitude to Prof Eulert for giving me this opportunity. Special thanks also go to Prof Rajasekaran and the entire Arthroplasty and Trauma Department (Dr Dhanasekaran, Dr Rajkumar, and other arthroplasty fellows) for imparting knowledge. I also wish to thank Dr Balavenkart and Dr Ajoy for making sure our stay at Coimbatore was social as well. I particularly enjoyed the team work of the members of the operating theatre and members of staff of GMCH. I am grateful to the entire family of Prof Rajasekaran for hosting a befitting dinner for us.



"Action is the foundation of success...". I have acted by coming to India and await the success that follows action. I will forever call to mind the contribution of this facility to my professional development.

Expert Corner

Surgical Management of Bankart Operation

Jacinto Monteiro & Marco Sarmento

Orthopaedic Department, University Hospital of Santa Maria, Academic Medical Centre - Lisbon, Portugal

Shoulder instability is a very common symptomatic problem and should be separated from minor or major instability related to laxity. Instability itself varies from patient to patient, regarding symptoms, and is affected by age and gender.

In patients less than 20 years of age the chance of recurrence is 60-70% and in patients older than 40 years it is less than 10%. Age is the main predictor factor in terms of recurrence.

Our criteria to propose a surgical treatment is related to the age of the patient, the number of episodes, direction, degree, aetiology of the dislocations, and the presence of structural lesions.

Bankart lesions, labral or osseus, are pathognomonic of traumatic instability of the shoulder, and when isolated, without any other structural lesion, have the best results with Bankart procedure.

We do not recommend routinely stabilising the young patient after the first episode of shoulder dislocation, unless we are in the presence of a high performance athlete or when the patient has persistent complaints of minor shoulder instability in his/her activities of daily life or in sports.

We do not consider proposing to operate a patient who voluntarily produces the instability.

Management:

After an adequate clinical evaluation supported by imaging exams (X-ray, TC, MRI or arthro-TC or arthro-MRI), we discuss with the patient what the proper procedure to solve his particular problem would be. It is very important to consider the functional expectations of the patient, the sporting activity performance expected, and the labrum/bone lesions presented.

The Bankart technique is the standard surgical procedure which we perform on our patients, and it accounts for about 90% of our surgical techniques for shoulder instability.

During the last 20 years we have performed the Bankart operation by an open technique using suture anchors to reattach the labrum with an average of 2/3 sutures per patient. Anterior capsular shifting was used in more than 80% of the patients as a complementary procedure.

In the last 4 years, we have been changing the Bankart technique to the arthroscopic approach. With arthroscopy, the large spectrum of lesions have been better recognised, mostly those from the posterior part of the shoulder. Also the quality of the repair became more accurate (localisation of the anchors and the amount of tissue mobilised and fixed) and this has resulted in a better recovery time and the same overall satisfactory outcome, with the same recurrence after repair.

Surgical Technique:

We do the Bankart arthroscopic procedure in the beach chair position with the arm to be operated in a free position. The beach chair position is our goal for all arthroscopic procedures, so it is routinely and easily set up by the operating room personnel. On the other hand, it helps the surgeon to be customised in spatial orientation, by doing all surgical approaches in the same manner.

The surgery is performed routinely under general anaesthesia, which is normally associated with an interscalenic brachial plexus block to control pain in the first 24 hours post-op.

Portals:

We begin the arthroscopy by a posterior portal, and after the diagnostic tour of the inside of the shoulder, we complement the access by doing anterior and anterosuperior portals.

With a probe and changing the visual portal we finish our diagnostic part.

When there are only Bankart labral lesions, we try to mobilise the scarring labrum and stimulate the native bed of it. We start to fix with the most inferior part of the labrum and try to put the first anchor a little articular to the edge of the glenoid and the field is controlled with the scope in the anterosuperior portal. We use on average 2/3 anchors when an isolated Bankart lesion is present. Normally the first anchor is double loaded because it allows us to reattach the labrum in a wider position with the trickiest anchor placement.

In those cases where the Hill Sachs lesion has more than 25% of the size of the humeral head and when an

external rotation and abduction motion of the upper limb put the lesion in an engagement position in the anterior glenoid rim, a remplissage is done. This infraspinatus tenodesis is performed firstly (before the labrum reattachment) in order to get more space in the posterior articular zone to achieve a better visualization.

In those patients doing high performance contact sports or with overhead demanding activities, and in those who had a huge number of dislocations with a bad quality or inexistent labrum, we convert the surgical procedure in an open Latarjet.

Post-operatively:

After the arthroscopic surgery the arm is suspended in a sling with a pillow between the arm and the chest to maintain the upper limb in a neutral position during 2 weeks.

The patient is allowed to be an outpatient the day after.

Between the 10th and the 15th day the stitches are removed.

The patient is taught to exercise the arm with pendular and circular exercises on the second day after the operation. The passive range of motion begins with physiotherapy supervision with external rotation limited to 10° and anterior flexion and abduction to 90° until 6 weeks. Active exercises and passive assisted exercises are then allowed over the initial limits.

The return to full athletic activities is not recommended before the fourth month and this is extended to six months in contact sports (karate, rugby, judo).



Fig. 1: Metallic anchors position after open Bankart repair (AP view)



Fig. 2: Metallic anchors position after open Bankart repair (Axilar view)



Fig. 3: Typical acute shoulder dislocation (right arm)



Fig. 4: Patient in beach chair position for a Bankart arthroscopic procedure

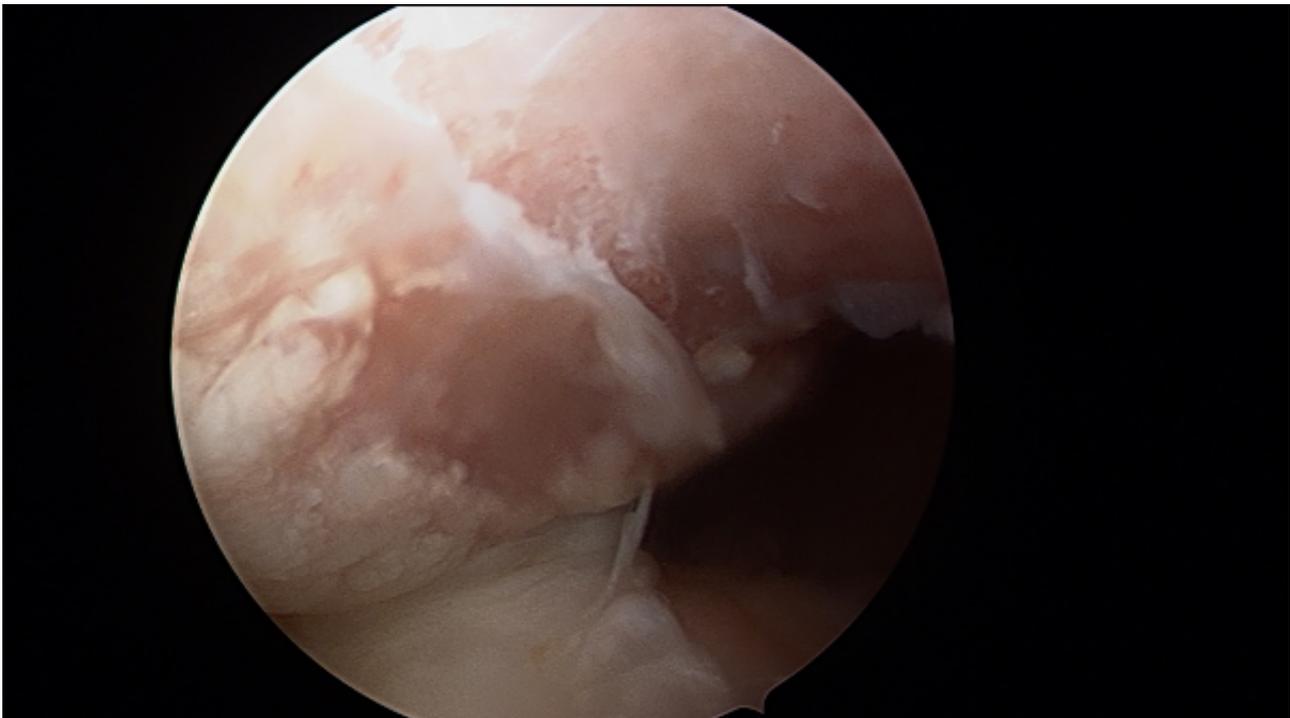


Fig. 5: Hill Sachs lesion in an anterosuperior view

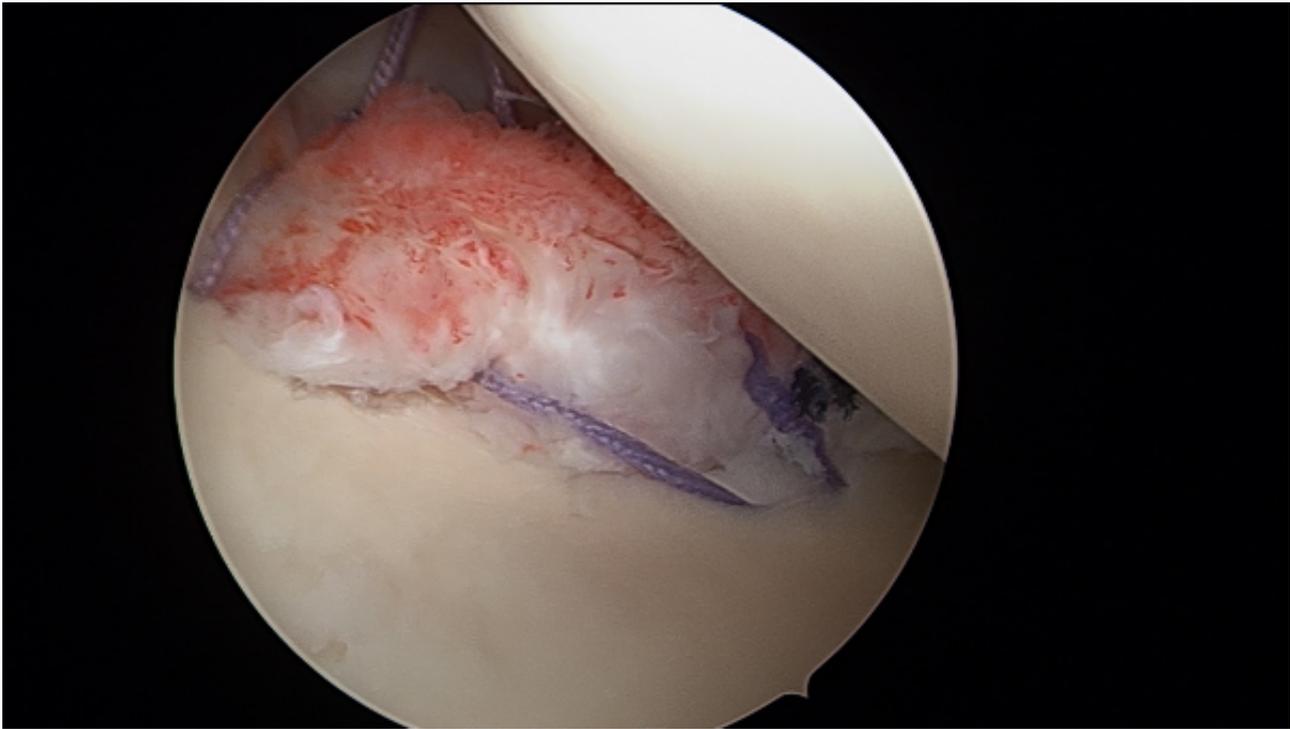


Fig. 6: Slight articular position of the most inferior double loaded anchor



Fig. 7: Bankart lesion between the 2 and 6 o'clock positions in a left shoulder

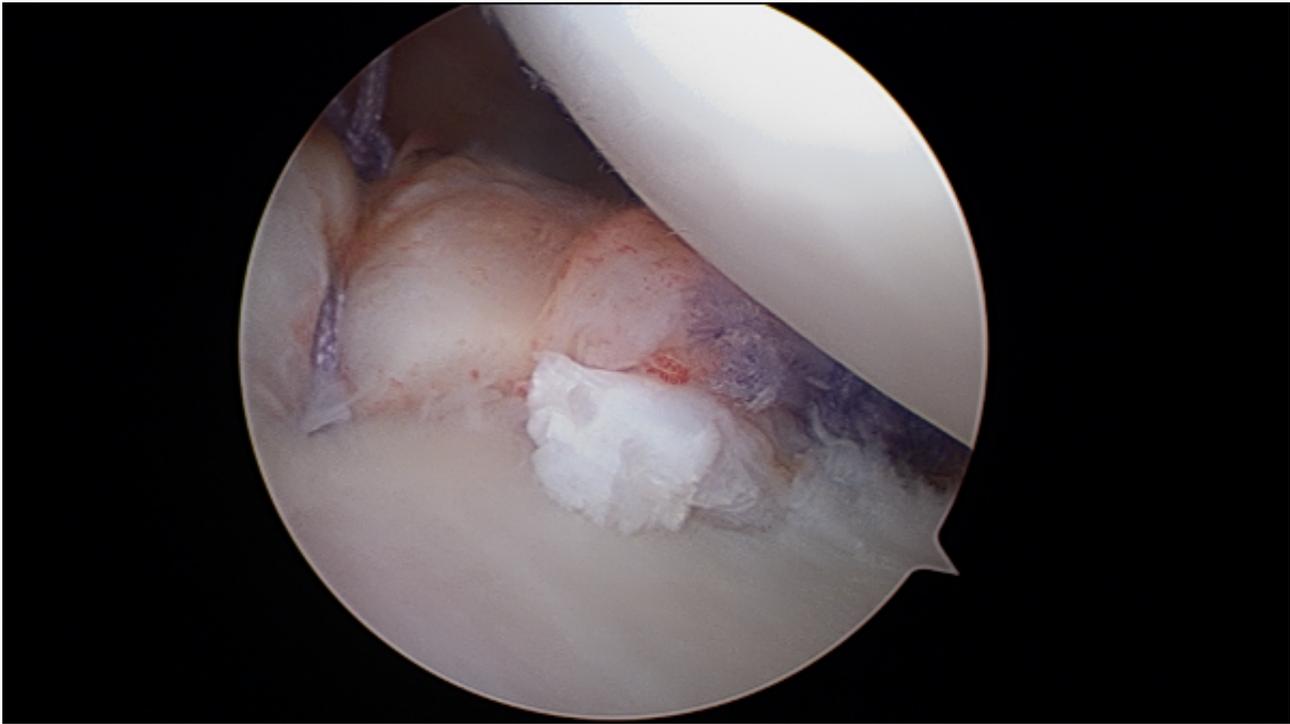


Fig. 8: Labrum reattachment and the fold created

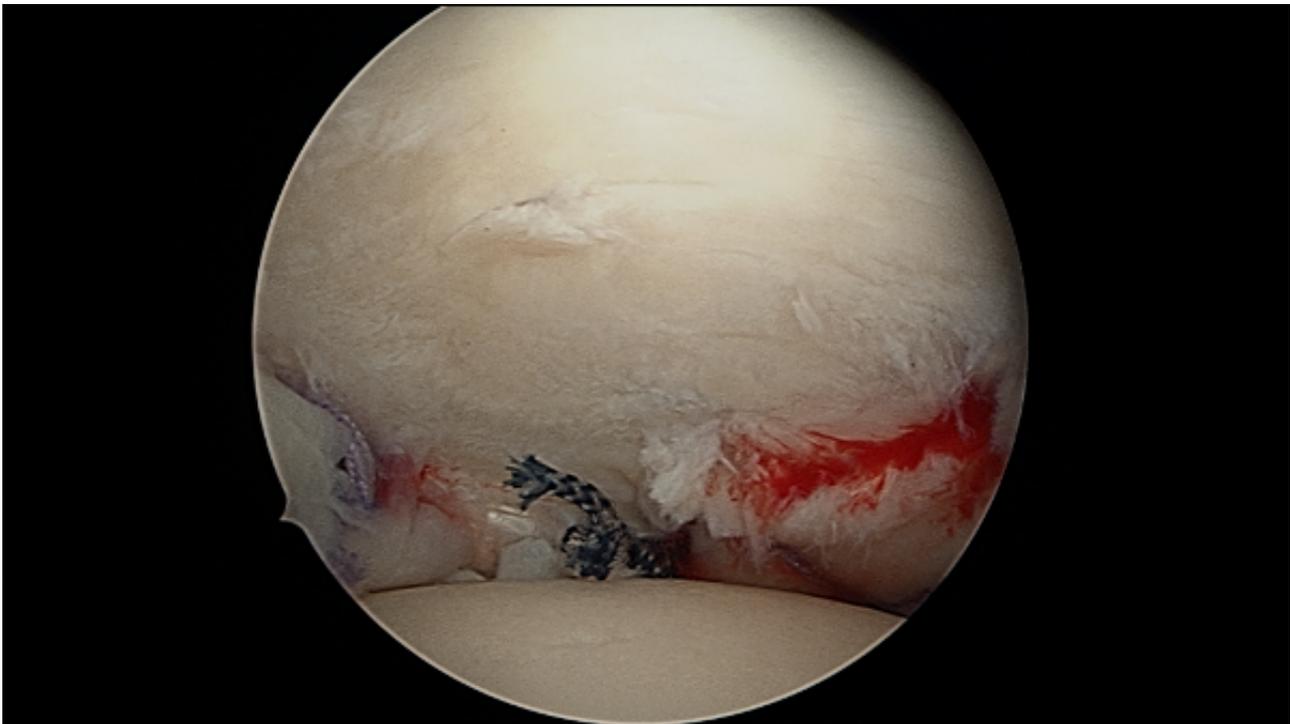


Fig. 9: Humeral head centered in the glenoid after the Bankart repair in an anterosuperior view

History of Orthopaedics



Hippocratic Oath... A pledge, The journey, Our destiny (Part 2)

Hitendra K. Doshi

SICOT National Delegate of Singapore

[\(To read part one, please click here.\)](#)

One may then seek to know the method of developing the ability to discriminate. The teacher in the oath also gives a solution as the oath advises not to please anyone at the expense of the life of a patient. Hence, it is cautioning the doctor to be mindful that any treatment offered should be for the best interest of the patient without any tinge of self gratification. This is a quality of 'selflessness' that we have pledged and with such a virtue, the mind is sanctified.

Such purity of thought results in positive discrimination. This is the 'purity of life' and 'art' that Hippocrates relates to in the oath. More interestingly, it teaches us that such noble values are inherent in man and, hence, Hippocrates correctly uses the word 'preserve' with regards to the purity that already exists in every human being including doctors. If a well is polluted with muddy water, the bottom of the well cannot be seen. However, as the mud is cleared, the bottom of the well becomes more visible. This analogy should stimulate the mind of a man to realize the fundamental truth of his own purity that is ever existent. A doctor has to be free from negative imaginings, inferences, emotions and egoistic desires. Having sharpened our intellect in understanding the purity of life and art, Hippocrates goes on to teach us the methodology of keeping impurities at bay.

The spirit of 'contentment' and 'sacrifice' is unveiled in the following lines that read: "I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art". If a patient is not diseased and treatment is administered, it is deemed unethical. However, the inference from the oath is that if a patient is diseased, even an appropriate treatment which is justified medically can be unethical too if other more economical treatments are not considered first. This is yet another challenge to the practice of 'value based medicine'. Hippocrates wisely reminds us that appropriate treatment administered becomes unjust if monetary gain is the ultimate desire. A doctor may give primary importance on the monetary profits and less importance on the procedure of choice for the well being of the patient. However, the oath obliges the doctor to regard earnings as a secondary gain resulting from the work done primarily for the well being of the patient. Therefore, a doctor should treat with the spirit of placing the welfare of the patient on the highest pedestal above one's own desires. Though money is important, the oath teaches us to exercise discretion when deciding on the treatment and charging a fee. A correct fee may be charged to the wealthy, but a doctor should be kind and considerate to the poor. It should become second nature for a doctor to sacrifice power, position, name, fame, time and money for the welfare of the patient. With such a spirit of satisfaction, contentment and sacrifice, there will be no competition with another doctor in earning huge sums and acquiring more and more possessions. That is the spiritual message of Hippocrates as he guides in the second line of this pledge, to have no hesitation to refer a patient to another doctor who will be of best interest for the well-being of the patient. Nevertheless, the attitude of competition which has its benefits should be constructive in nature and should enable a doctor to realize the nobility of the profession. To be able to discriminate promptly and effectively, the teacher in the oath reveals yet another method.

The value of detachment from the senses and external attractions is expressed in the following part of the oath that reads: "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves." The vulnerability of man in adhering to the righteous path is eminent as he is exposed to external influences through the senses. As a doctor, such vulnerability can cause ill effects to the patient and the doctor himself. Therefore it is repeatedly emphasized that the intention of the doctor when faced with a patient should be pure in ensuring the well-being of the patient without any personal interest. That should be the sole desire of practice by a doctor. Instead, if a doctor lives a life solely to fulfill his material and sensual desires, then medical practice will be in accordance to the attachments to such temptations. Particular emphasis is given by Hippocrates to be uninvolved with pleasurable emotional bondage when treating a patient. This is to illustrate the vulnerability of emotions. An emotion is indeed a natural instinct of man and it is inherently present in its pure form. However, when emotions are allowed to run unabated, it can be detrimental and result in immoral attachments. Therefore, for a doctor to be able to perform a duty solely for the well being of the patient there should be no room to entertain any personal desires and emotions. It is only with such awareness that a doctor can conduct himself intentionally with professionalism and nobility.

"All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal", is the final pledge taken before the concluding statement. Having reassured oneself of the dignity and virtues of a doctor, the conscience will be clear that the relationship of the doctor which is established with a patient through the profession is 'pure' and 'trustworthy'. As a doctor, all personal information of the patient is retrievable from the history taken as it is a requirement to be able to diagnose and treat appropriately. That is the trust and faith the patient has on a doctor and hence the doctor must also be true to himself that the information obtained will be utilized solely to restore the well being of the patient and not shared if there is no justified need. The oath here also reveals the value of being 'respectful' and 'truthful'. A doctor must respect the dignity of the patient. It is only by the virtue of being respectful and truthful to the patient that a doctor can receive respect and truthfulness from the patient in return. Therefore, it cannot be overemphasized that the oath here demonstrates the latent values of trust, faith, respect and truth which are the guiding walls in the path of a life of a doctor. Having taken an oath which spells out loud and clear the inherent human values, a doctor is indirectly compelling himself to take the path of nobility. Every word and every line of the oath has a message of deeper significance which should guide a doctor in his practice. If the oath is uttered without reflection on the directives given, a doctor will remain oblivious and hence choose a different path which

could lead him astray from his destiny. Therefore, the journey of a doctor is practicing the essence of the 'Hippocratic Oath'. It promotes the philosophy of 'value based medicine' which all doctors should live by in order to realize that doctors are destined to be noble.

However, for the minds which doubt and question as to why such virtues leading to nobility need to be practiced by a doctor, Hippocrates gives a divine answer with affirmation in last breath of the oath which reads: "If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot". This concluding statement of the oath reassures a doctor, that he will enjoy his life in spite of all sacrifices made. It promises the doctor that happiness and delight will be the grace in return, if virtues of the oath are held faithfully. The sacredness of the oath taken ensures respect from all in the present time and for generations to come. The oath indirectly awakens us to realize the very fact that when the hour of judgments is upon us, we won't be able to carry with us the wealth we have amassed. Instead, the sacrifice and devotion of a doctor will remain for generations and will be the invisible garland that tells his tale. The oath further affirms that, if a doctor violates human values and deviates from righteousness, he will never be happy as sadness, grief and disrespect will be the punishment he will have to endure in exchange. Hippocrates makes a salient point that man ultimately wants happiness and this can be achieved and experienced only when the flag of human values are kept flying high. Though the journey of medical practice may be fraught with challenges, we should walk the terrain with steadfastness and not give in to momentary delusions of enjoyment at the expense of human values. Instead, Hippocrates guides us to yearn for eternal joy.

In conclusion, the 'Hippocrates Oath' is indeed a pledge, guiding us on our journey to reach our destiny. It is indeed an inward 'awakening' when we realize the principle of 'simple living' and 'high thinking', Hippocrates himself had adopted in his life all those years ago and then later out of pure generosity penned it down for the rest of us in the form of an oath. The oath must become a 'mantra' in the conscious mind, to enable its significance to echo constantly in the subconscious mind. We should not be hypocrites and instead be 'Hippocrates' in thought, word and deed directly manifesting the divine directions of the oath.

TKA: Similar revision rates and outcomes for all-polyethylene and metal-backed components

Title: All-polyethylene tibial components are equal to metal-backed components: systematic review and Meta regression

Authors: Nouta KA, Verra WC, Pijls BG, Schoones JW, Nelissen RG, Department of Orthopaedics, Leiden University Medical Center, Postal Code J11R, PO Box 9600, 2300 RC Leiden, The Netherlands

Clin Orthop Relat Res. 2012 Dec;470(12):3549-59.

doi: 10.1007/s11999-012-2582-2. Epub 2012 Sep 13

Published Date : December 2012

Level of evidence: Level II - Meta-analysis

PMID: 22972656

Type of Study: Meta analysis

Synopsis

26 articles (12,500 TKAs with 231 revisions) were identified to compare the clinical outcomes (revision rates and clinical functioning) of metal-backed and all-polyethylene tibial component in primary TKAs. Results indicated that there were no differences in revision rates or outcome scores between the two components, except for higher migration of the metal-backed components and less migration of all-polyethylene components.

Why was this study needed now?

While metal-backed tibial components are used in the majority of TKAs, the all-polyethylene component has been frequently recommended. However, it is unclear whether one component would display a superior performance over the other. Hence, this systematic review aims to investigate whether the metal-backed tibial component would be clinically superior to the all-polyethylene tibial component in primary TKA in terms of revision rates and clinical functioning. Additionally, this systematic review focuses on determining which modifying variables would affect the revision rate.

What was the principal research question?

Does the metal-backed tibial component provide clinically superior outcomes compared to the all-polyethylene tibial component in primary TKAs with regards to revision rates and clinical functioning?

Study Criteria

- a. *The following databases were searched:* PubMed, Embase, Web of Science, Cochrane, CINAHL, and Academic Search Premier. Furthermore, the journal databases for Science Direct and Wiley-Blackwell were searched.
- b. *Index Terms:* Index terms included: "polyethylene", "arthroplasty", and "knee replacement".
- c. *Study Selection:* The articles had to meet the following inclusion criteria:
 1. The study had to be a comparative study.
 2. The intervention(s) assessed had to be all-polyethylene and metal-backed tibial components in primary TKAs for end-stage osteoarthritis or rheumatoid arthritis with the results separately reported.
 3. The metal-backed tibial components needed to have a fixed-bearing design.
 4. Outcome measurements in the studies had to include survival rates, clinical measurements, or functional measurements with minimal follow-up of 6 months. The articles were excluded if: 1) The study did not meet the inclusion criteria for title and abstract, and 2) the population had been reported in another included study).
- d. *Data Extraction:* Two reviewers (KAN, WCV) independently extracted data concerning summary patient demographics, methods, interventions, and outcomes. Disagreements in study and data extraction were resolved through consensus with a third reviewer (BGP).
- e. *Data Synthesis:* The 26 selected articles (11 RCTs and 15 non-RCTs) comprised of 2700 all-polyethylene and 9978 fixed-bearing metal-backed tibial components used in TKAs with 231 revisions for any reason. The review tested heterogeneity between studies with the I-squared statistic. Possible sources of heterogeneity were explored through meta-regression using the random-effects regression model. The random-effects model was used to combine all data for meta-analysis according to the pooled Mantel-Haenszel test for risk differences (RDs) and the pooled standard error for mean differences (MDs). Metafor package for R Version 2.13 was used to perform all analyses.

What were the important findings?

- No differences in revision rates were displayed between the two tibial components; the revision rates were 0.975 (95% CI, 0.959-0.992) for the all-polyethylene component and 0.973 (95% CI, 0.959-0.988) for the metal-backed component.
- The meta-regression for the primary outcome indicated an improvement in the all-polyethylene component with time compared with the metal-backed component.
- No differences were displayed in the secondary outcome measurements: ROM, The Knee Society Score (KSS), and Hospital for Special Surgery (HSS) scores between both components. Additionally, there were no differences in radiographic femorotibial alignment, anterior tibial alignment, and tibial slope between the two types of designs.
- All-polyethylene tibial components resulted in less migration compared to metal-backed components as the maximum total point motion (MTPM) for cemented tibial components using radiostereotactic analysis (RSA) indicated a mean difference of -0.29 (95% CI, -0.29, -0.21) favouring the all-polyethylene component.

How will this affect the care of patients?

This review suggests that the use of an all-polyethylene tibial component in TKA is an effective, safe treatment for end-stage osteoarthritis of the knee. However, further studies may be required before reconsidering the use of this component design.

What should I remember most?

There were no clinically relevant differences in revision rates, clinical function, or radiographic variables between the metal-backed and all-polyethylene components.

References:

1. www.myorthoevidence.com



2. Pubmed: www.ncbi.nlm.nih.gov/pubmed/22972656
3. Clinical Orthopaedics and Related Research, Volume 470, Issue 12, pp 3549-3559



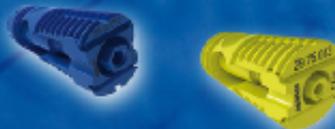
PAEDIATRIC ORTHOPAEDICS

As we have always set a high value on developing products for people suffering from foot deformities, we now also focus on **our little patients** and on their special needs.

We are pleased to inform you about the **extension of our product range**. In addition to our products for foot, hand and craniomaxillofacial surgery we now develop innovative product solutions for paediatric orthopaedics.

Our **first product** for paediatric orthopaedics is already on the market.

- **DocPrice VARIO SUBTALAR Screw System**



Further products are in the pipeline and will soon be available

- **FENDER System 3.5 / 4.0**
- **EASY STOP Screw 6.2**



For more detailed information about the mentioned products please contact us:

The specialist for small bones



Normed Medizin-Technik GmbH
Ulrichstraße 7 | 78532 Tuttlingen / Germany

Tel. +49 (0) 7461/93 43 0
Fax +49 (0) 7461/93 43 20

info@normed-online.com
www.normed-online.com
www.normed-academy.com

Editorial Department

Editorial Secretary: Hatem Said

Editorial Production: Linda Ridefjord

Editorial Board: Ahmed Abdel Azeem, Syah Bahari, Kamal Bali, Bassel El-Osta, Anthony Hall, Shalin Maheshwari, Maximilian Rudert

Rue Washington 40-b.9, 1050 Brussels, Belgium

Tel.: +32 2 648 68 23 | Fax: +32 2 649 86 01

E-mail: edsecr@sicot.org | Website: www.sicot.org

Disclaimer: Some of the views and information expressed in this e-Newsletter include external contributors whose views are not necessarily those of SICOT. SICOT is not responsible for the content of any external internet sites.