Issue No. 62 - November 2013

SICOT e-Newsletter

Editorial

CME is not only a duty but also a right to claim

Jochen Eulert
SICOT Secretary General

In almost all countries, society demands continuous medical education and training from the individual doctor and worldwide it is seen as his essential duty. Many, if not all, areas of society look for a well-trained and experienced doctor:

- Governments require the best treatment for citizens/voters;
- Insurance companies require the best treatment for their clients;
- Hospitals/Employers require well-trained surgeons to have full beds;
- Industry requires doctors who are capable of using their instruments properly;
- CME authorities require continuous education/training;
- And require re-certification for established doctors.

Above all (and he is absolutely right):

- The patient requires safety and wants to be treated by a well-trained surgeon.

But this duty cannot be left to the doctor's discretion alone considering it as some kind of private activity. Continuous education must not be a one-way road where the doctors undertake learning and teaching by offering their time and financial resources whilst society reaps all the benefits. Society and in particular the different players in the health care systems also have some responsibility in this process by setting up acceptable conditions to allow the individual doctor to obtain the education and training he or she needs to treat his or her patients properly under modern conditions.

Congresses and courses represent an ideal platform to offer the necessary scientific information and educational tools. The following conditions should therefore be provided by society:

- 10 days' leave per year to attend congresses and courses;
- Financial support from the employer;
- Financial support (educational grants) from industry through national or international societies (vs. compliance);
- Costs to be allowable against income tax.

Postgraduate education and training is not only a duty but should also be recognised as a right that every doctor should demand to be educated to the level of knowledge and skills needed to provide ideal patient care.

SICOT, together with national and international orthopaedic societies, should start a worldwide campaign to defend this right throughout every corner of the globe.

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

Abstract submission is open here!
Congress registration will open soon on the SICOT and SBOT websites.

SICOT News

- **The SICOT Head Office relocates**

After 29 years, SICOT is leaving Rue Washington 40 in Brussels. As from 1 December 2013, the SICOT Head Office is located at Rue de la Loi 26, Brussels. All postal correspondence should be sent to the new address below from now on. The telephone and fax numbers will remain the same.

Rue de la Loi 26 - b. 13
1000 Brussels
Belgium

- **20th SICOT Trainees Meeting**

The 20th SICOT Trainees Meeting will be held on 16 December 2013 in Cairo, Egypt. It will include presentations by young surgeons under 40 years of age and plenary lectures by senior surgeons. Three prizes of up to EGP 1,000 each will be awarded to the three best presentations and all presenters will receive certificates of presentation and attendance. For more information, please contact20thsicottraineesmeeting@gmail.com.

SICOT Global Network for Electronic Learning - SIGNEL

Article of the Month

November 2013

Antithrombotic prophylaxis in major orthopaedic surgery: an historical overview and update of current recommendations

Plamen Kinov, Panayot P. Tanchev, Martin Ellis & Gershon Volpin

The risk of venous thromboembolism following major orthopaedic procedures, such as joint arthroplasty and hip fracture surgery, are well recognised and represent one of the major challenges in orthopaedic practice, having in mind the increasing number of arthroplasties of the hip and knee done worldwide per year and their successful outcome. This potentially fatal complication remains a challenge in orthopaedic practice. The percentage of patients in whom antithrombotic prophylaxis has not been administrated or has been inadequate may reach 50%. Until recently, anticoagulant prophylaxis with low molecular weight heparins (LMWHs) has been a "gold standard". LMWHs are indirect inhibitors of the clotting factors Xa and thrombin and are administered by daily subcutaneous injection. Their efficacy has been proven in numerous clinical trials and the rate of complications with their use is relatively low. However these compounds are associated with a failure rate and are inconvenient to administer, requiring subcutaneous injection, leading to inadequate compliance. For these reasons postoperative thromboembolism continues to occur in up to 10% of this patient population. Recently, novel oral anticoagulants have been introduced into practice for thromboprophylaxis after joint arthroplasty and hip fracture surgery. These drugs are direct thrombin inhibitors (dabigatran) or direct factor Xa inhibitors (rivaroxaban, apixaban and edoxaban). These oral drugs have the same efficacy as the LMWHs with the same or slightly more clinically significant haemorrhage as their main side effect. Their ease of administration and favourable clinical profile makes them an important addition to the therapeutic armamentarium available for venous thromboprophylaxis. In this paper we review the aetiology and pathogenesis of venous thromboembolism and present the various alternatives for its prevention after major orthopaedic surgical procedures with emphasis on the new oral drugs.

International Orthopaedics (SICOT)
DOI 10.1007/s00264-013-2134-8

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Case of the Month

November 2013

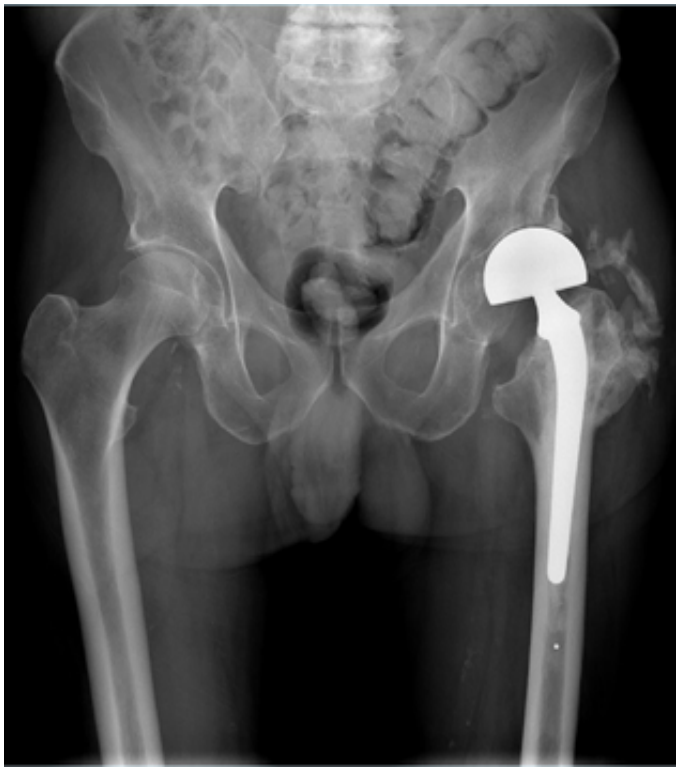
Authors: Syah Bahari & Tom McCarthy
Department of Orthopaedic Surgery, St James' Hospital, Dublin, Ireland

History

A 69-year-old male presented to the Emergency Department complaining of progressive pain in the left hip. He was able to mobilise using the walking frame. He denies any history of fall. He recently had a bipolar hip hemiarthroplasty for intracapsular neck of femur fracture 6 months earlier. He also has a background history of Parkinson's disease, osteoporosis, hypertension and depression.

On examination, he was able to weight bear on the left leg but it was painful. Passive movement of the left hip was also painful. He had no temperature and his WBC, ESR and CRP was normal.

A radiograph of the pelvis was performed.



Q. What are your thoughts on the pelvic radiograph?

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There was heterotopic ossifican over the left hip. The bipolar hip prosthesis appeared to be subluxated. There is a suggestion of an acetabular fracture.

Q. What is your next investigation?

i. Judet's view of the left acetabulum
ii. CT scan of the left hip
iii. Isotope bone scan

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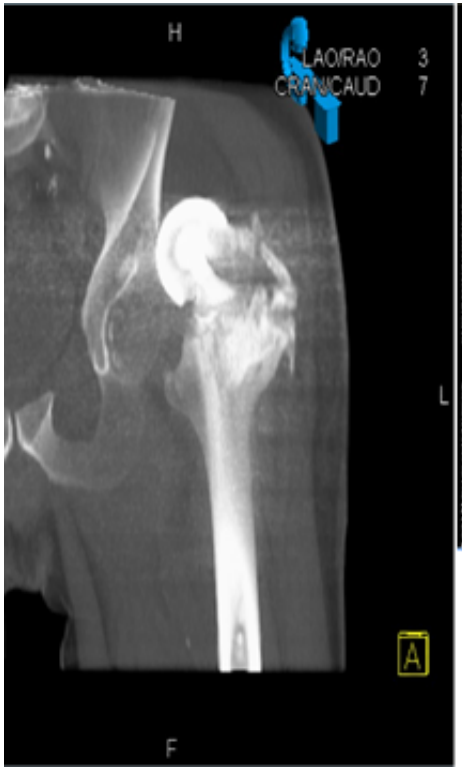
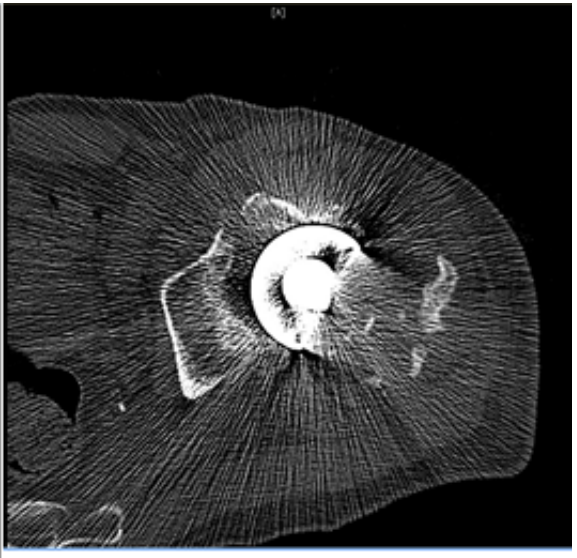
A CT scan was performed to further investigate the possible acetabular fracture and subluxation of the bipolar hip prosthesis.





The CT scan showed a fracture of the posterior wall of the acetabulum with erosion of the superior aspect of the acetabulum. The bipolar component was dislocated in relation to the acetabulum.

An isotope bone scan was also performed and showed increased uptake in the region of the superior and anterior margin of the acetabulum and in the area of heterotopic ossification.

Q. What is your management plan for this patient?

i. Closed reduction and abduction brace
ii. Revision arthroplasty with retention of stem
iii. Revision of both components

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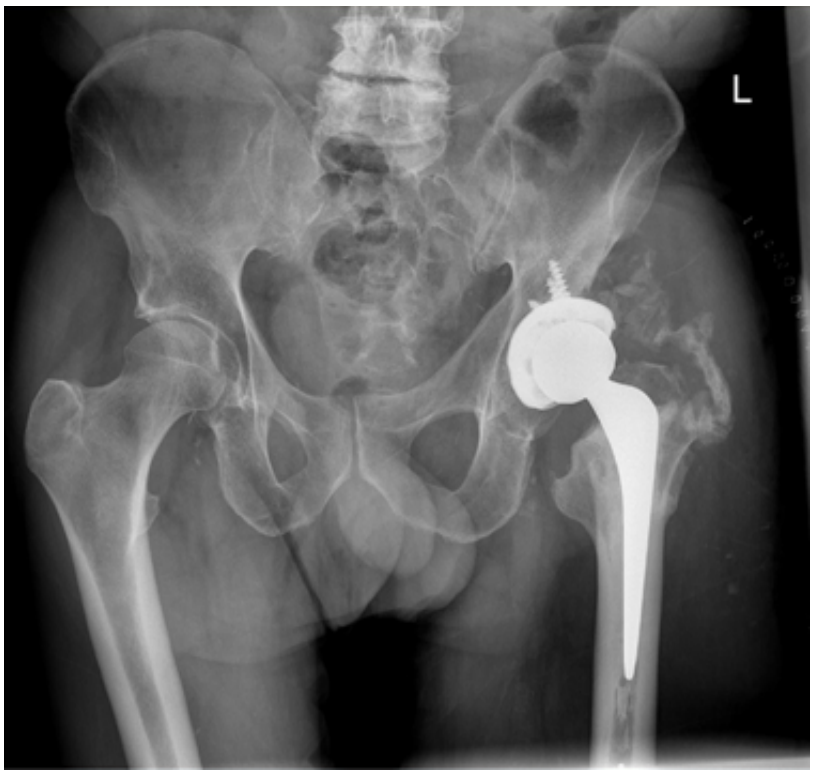
Treatment

Patient had a complete revision arthroplasty. The rationale was because he had a cemented Charnley stem with a 22.25mm head. This will limit the option with regards to the acetabular component. Furthermore, with a background history of Parkinson's disease, there is a higher risk of dislocation. The stem was revised to an Exeter stem with cement in cement technique. Uncemented acetabular component with augmented screw fixation was used with 32mm femoral head.



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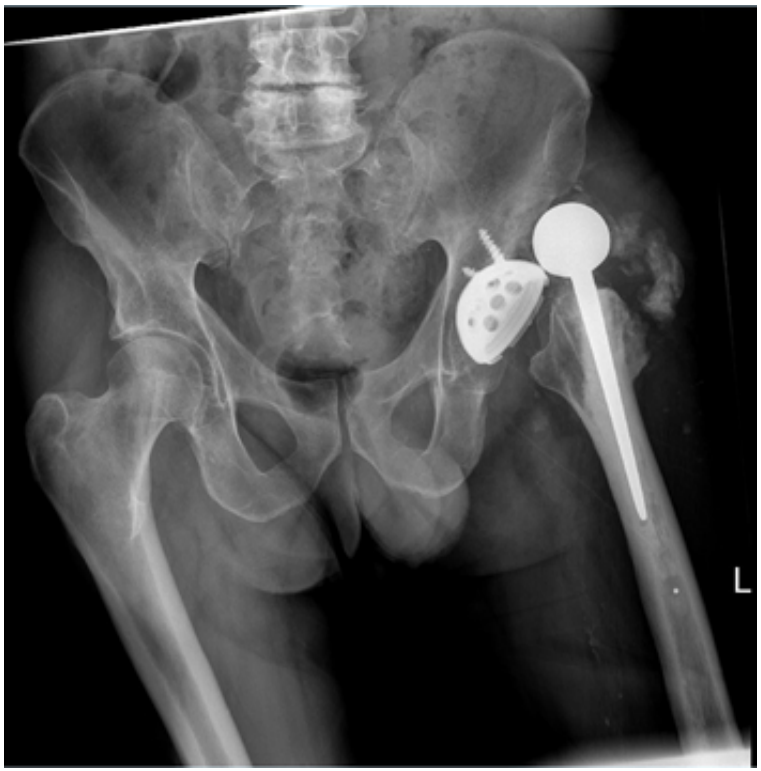
Patient was well postoperatively and was discharged for rehabilitation. He was later readmitted from the rehabilitation hospital with dislocation of the left hip prosthesis 2 weeks after the surgery. He denies any trauma.



Q. What is your next plan?

i. Closed reduction and abduction brace
ii. Open reduction and abduction brace
iii. Open reduction and revision

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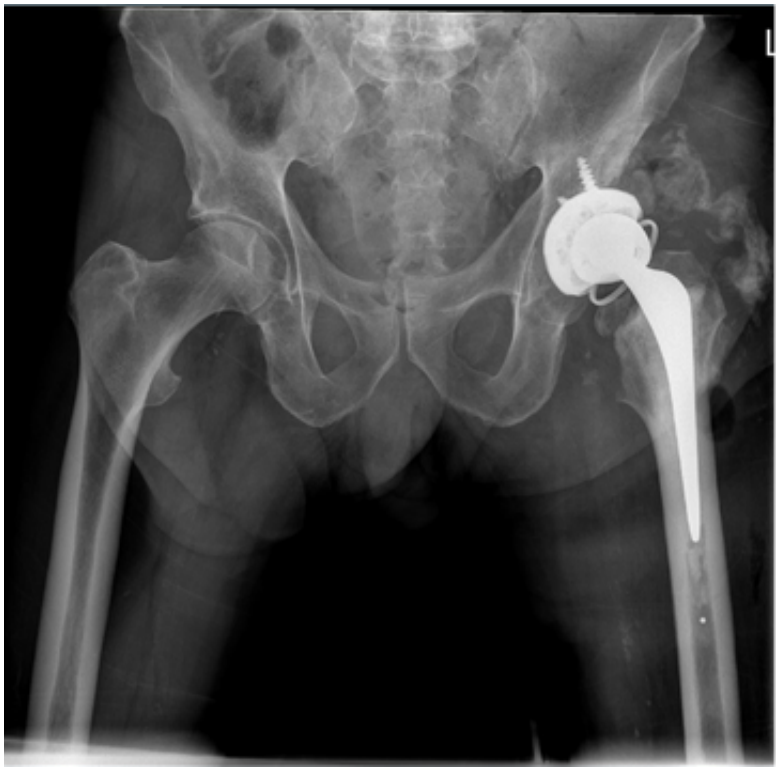
Closed reduction was attempted but failed to reduce to dislocation. In view of the early dislocation and his background history of Parkinson's disease, the hip was revised to a tripolar hip arthroplasty with a cup capture (Stryker).



Discussion

Hip dislocation after bipolar hemiarthroplasty is not common. Observational study suggests a risk of 1.5% dislocation rate [1]. Risk of dislocation is increasing in patients with neurological problems such as stroke involving the side of hip hemiarthroplasty. Reports on patients with Parkinson's disease having a THR showed an increased risk of dislocation compared to normal population [2]. However, we cannot find any reports in the literature on fracture dislocation of hip hemiarthroplasty in Parkinson's disease in the literature but acetabular erosion has been reported in patients reviewed at an average of 4 years after surgery [3].

The rationale of using this prosthesis in this case was due to the potential recurrent hip dislocation in view of the Parkinson's disease. The use of constrained acetabular component has been advocated for patients with hip instability with neuromuscular disorder [4]. The issue with early loosening is the main concern with using this prosthesis.

Reference(s)

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2. Weber, M., Cabanela, M. E., Sim, F. H., Frassica, F. J., & Harmsen, S. W. (2002). Total hip replacement in patients with Parkinson's disease. International Orthopaedics, 26(2), 66-68.
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Fellowship News

"SICOT meets SICOT" fellowship report from Hospital Infanta Leonor, Madrid

Dinesh Choudary
SICOT Associate Member - Chennai, India

I had the honour of being selected by SICOT for the "SICOT meets SICOT" fellowship programme at Hospital Infanta Leonor in Madrid, Spain. It is with great pleasure that I write to you this report after having successfully completed the fellowship during the months of April and May 2013.

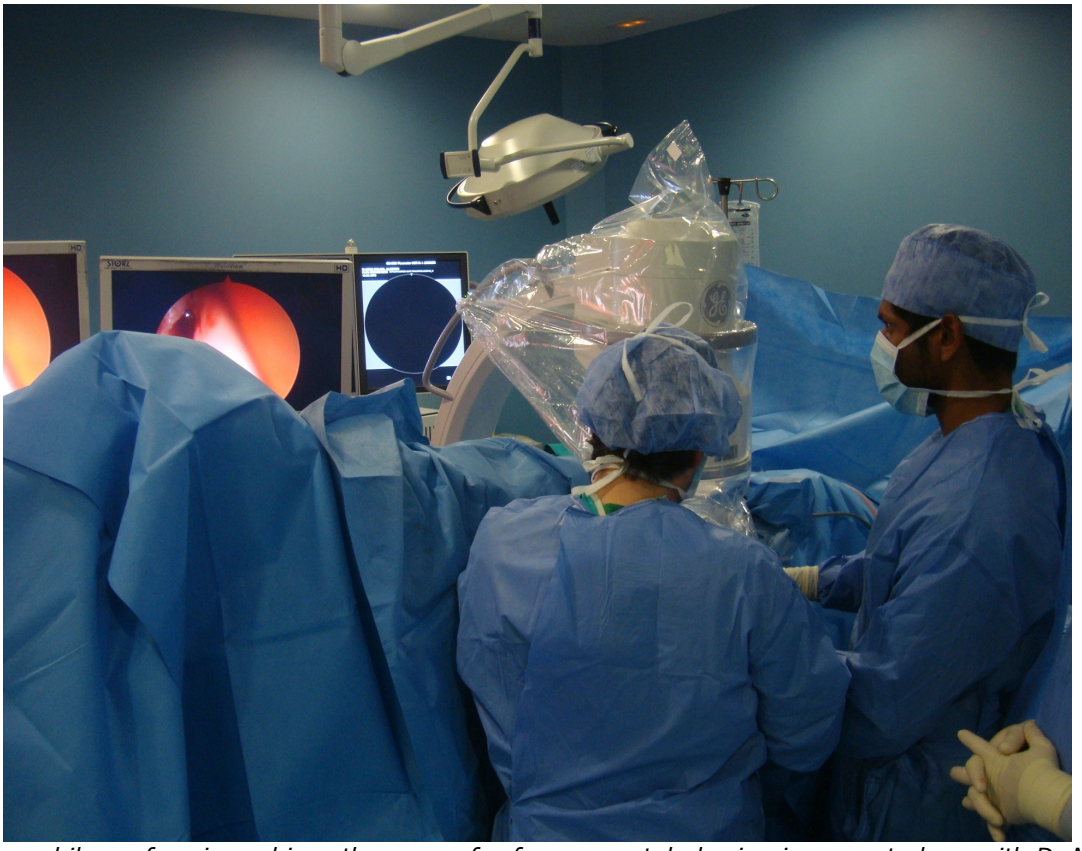
It is springtime in Madrid in April, which makes it the perfect time to visit. Hospital Infanta Leonor is a tertiary care health centre located in the outskirts of Madrid. It is a 350-bedded hospital with Dr Ricardo Larrainzar heading the Department of Orthopaedics. There are about 20 orthopaedic consultants working in the department, each one of them a pioneer in their field of speciality. I got to spend a lot of time with the knee chief Dr Raul Garcia-Bogalo along with the hand-wrist team headed by Dr Fernando Corella and the foot team headed by Dr Antonio Martin. But it was Dr Oliver Marin-Pena, the fellowship co-ordinator and the head of the hip team, who served as my mentor and guide during my stay in Madrid. It would only be an understatement if I said that his enthusiasm and teaching only has inspired me to work harder in becoming a better orthopaedic surgeon.

Since my areas of interest are primarily arthroplasty and sports surgeries, my schedule was tailored to make me participate more in these procedures. Each day began with the discussion of the cases admitted and operated the day before, followed by division of activities. I got to attend the OR almost every day and from the very first day was scrubbed in as 1st assistant. I got to participate in a number of interesting surgeries such as Navigated Arthroscopic ACL repairs, ankle arthroscopy, first MTP joint scopy, scaphoid fracture fixation using arthroscopy, to name but a few. I gained immense knowledge and inputs while working with Dr Marin-Pena, a pioneer of hip arthroscopy in Spain. He is also a trained hip resurfacing arthroplasty surgeon and my experience with him vastly increased my knowledge of arthroplasty.

I was also fortunate enough to attend the National Arthroscopy Conference of Spain which was held in San Sebastian from 24 to 27 April 2013. There were numerous presentations and lectures on various subjects relating to the field of arthroscopy. A number of prominent arthroscopic surgeons attended the meet, including Dr Lafosse, Dr Kerkhoffs, Dr Oscar Ramirez and Dr Hatem Said to name a few. I was privileged and indeed delighted to get a chance to interact with them and learn from their experience.

Of course, no trip to Madrid is complete without watching the Real Madrid football team in action. And I got to do just that, thanks to the staff at Hospital Infanta Leonor and now I can proudly say that I am one of those lucky people who got to see Ronaldo score a goal. My heartfelt gratitude goes to this noble organisation, SICOT, which is a boon to young orthopaedic surgeons like me. I will cherish this imperishable and memorable experience all through my career. I wish and pray that I may be gifted to get associated with the future endeavours of SICOT and do quality service for the needy through the expertise gained from this reputed organisation.

Thank you.



Picture taken while performing a hip arthroscopy for femoroacetabular impingement along with Dr Marin-Pena

Picture taken during the national arthroscopy meet at San Sebastian, along with Dr Marin-Pena, Dr Hatem Said and Dr Fernando Corella (from left to right)

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