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Newsletter

Growing as an Orthopaedic Surgeon: from Economy to Business Class...

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Growing as an Orthopaedic Surgeon: from Economy to Business Class...

Hatem Said SICOT Editorial Secretary & SICOT-J Editor-in-Chief – Assiut, Egypt

You all remember your first Dynamic Hip Screw (DHS) surgery, how you felt exhilarated and proud of yourself, sharing your achievement with friends and family. What a great feeling when you do an operation for the first time. It is an integral part of life to be driven to achieve new things and bigger steps.

But do you remember your 15th DHS? Probably not. After a while it becomes routine, the thrill is gone, and you just come out satisfied you have performed a good surgery but shortly afterwards forget all about it. Instead, you are probably thinking of when you will be doing the next bigger surgery...

This is adaptation, a normal fact of life. It is what makes us seek progress and improvement to satisfy our desires. Of course we should set long-term goals and aims in life but usually we go through them one step at a time.

As a young surgeon, you may remember when you travelled to a scientific meeting, and you saw your senior surgeons going left to business class, while you went right to economy. What did you think then? How amazing it would be to be flying in business class instead of these cramped economy seats. The bigger screens, nicer meals, even bigger smiles from the flight attendants, and, to make things even worse, you probably paid for your ticket, while the senior surgeon was sponsored!!!

...but there are a few things you should know...

Firstly, the physical changes: as a young surgeon you can easily work all through the night and may need to continue during the morning hours (if the work regulations allow it), but, as you get older, your body is less tolerable to these unaccustomed stresses, as can be seen by the back pain most senior surgeons have or even osteoarthritis of the knees. Therefore, the economy seats are more of a torture for them than for you.

Secondly, the senior surgeons travel a lot more often as they are invited to many meetings when they become famous and renowned, thus it is more likely that they would be sponsored. Moreover, physically it becomes even harder to go through all this travelling in economy class.

Adaptation also plays a role. It is like upgrading your small manual car to a bigger more comfortable automatic car with air conditioning. You get used to the new one and you would have difficulty enjoying your older car as before, often wondering how you travelled for hours in it. Similarly, after you start flying business, it becomes more difficult and inconvenient to fly economy.

It is this adaptation which makes us buy a bigger car or seek to perform bigger and more complex surgeries, leaving the simpler ones to others. This is a necessary fact of life that makes room for younger surgeons.

On the other hand, you are probably enjoying the economy trip more and watching all the movies, plus making new friends who are by default 'invading your space'... but in business class, the senior surgeon is busy preparing all his last-minute lectures and not enjoying the larger screens as much. Plus, no one makes friends in business class, since everyone is separate, busy and not interested. At that level, business class becomes a necessity rather than a delicacy. Many may have to land and start work or give lectures shortly after, while you may have two to three days before or after the meeting to rest and enjoy the new place.

So, the message here is that you should enjoy 'life in economy class', which is reflected in the physically challenging working hours, the smaller car, and the lower pay, just as much as you enjoy your early surgeries, because each step in life has its own kind of enjoyments and requirements.



Residency in the Republic of Moldova





The Republic of Moldova is a developing country, famous for its wine industry and tourism located in the eastern part of Europe, between Romania and the Ukraine.

The State University of Medicine and Pharmacy 'Nicolae Testemitanu' plays an important role in the health sector. It was initially established in St. Petersburg (Institute of Medicine No. 1), but moved to Kislovodsk during World War II, transferring later to Chisinau, the capital of Moldova, and named the State Institute of Medicine. The Institute began its activity on 20 October 1945. The Orthopaedics & Traumatology Department was founded on 1 September 1962. The Chief of the Department is now Prof N. Capros. There are ten professors and they are renowned personalities in Moldova and abroad.

After a six-year university degree, the residency consists of a five-year training period and is recognised in hospitals accredited by the university.

In order to be accepted in a trauma residency, the student has to obtain high marks in the final exams, which is composed of a final oral exam, practical exam, multiple choice test, graduation thesis, 20 subjects linked to the specialty and the six-year general mark.

The training period has specific educational issues introduced for different years, which are developed and realised by each resident. The trainee is expected to rotate through adult and paediatric trauma subspecialties for at least 11 months. To qualify for the exams, the candidate must have submitted his log book with other documents showing the performed procedures each month. At the end, the examinations test the summative knowledge of the candidate involved.

If a trainee is successful, he/she will progress to the next 11-month phase of training, where he/she is expected to rotate through various surgical subspecialties, such as topographic anatomy and operative surgery, anaesthesia, intensive care, clinical toxicology, clinical pharmacology, general surgery, thoracic surgery, vascular surgery, neurosurgery, oral maxillofacial surgery, oncology, urology, osteoarticular tuberculosis and burn injuries in specialised and accredited hospitals. The resident is required to perform established procedures and surgeries, ending with a module final exam.



The third year of training is dedicated to paediatric orthopaedics and a continuation of adult traumatology. Each candidate must have submitted his log book of performed procedures while sitting for a final year MCQ and oral exam.

The fourth and fifth years have the purpose of increasing knowledge in adult orthopaedics. During the 5 years of training, the doctor must carry out original research and write a thesis which will be presented and defended orally at the final examinations. At all stages, the candidate is expected to be actively involved in the management of all patients and carry out procedures. He/she is entitled to a nine months' clinical attachment which he/she can do at any hospital during the third, fourth, and fifth years (three months).

Teaching during the residency periods consists of informal and formal teachings. The informal teaching is in the form of outpatient clinics, ward rounds and theatre sessions, while the formal teaching takes place during the update courses, annual conferences, national congresses, and meetings abroad. The resident is also expected to present a preliminary thesis and follow up patients at such meetings.

After satisfactory completion of each of the stages, the resident will have to take exams, which consist of an unknown patient for surgical intervention that will be done by the resident, multiple choice tests, and oral exams. There is also a presentation of the final thesis with viva at the fellowship examinations. The resident then qualifies as a general orthopaedic surgeon, if successful in the fellowship examinations. However, the resident is encouraged to proceed to a post-fellowship training in any subspecialty in orthopaedics that is of interest to the individual.

Orthopaedic training in the Republic of Moldova can be very demanding and challenging due to the population of the country and the small number of training centres. The orthopaedic surgeons and orthopaedic residents are exposed to a wide variety of cases, the bulk of the work being trauma cases.

The journey to becoming an orthopaedic surgeon can be very tough like running a marathon. It gets tougher with each mile but finishing the course with the reception of the fellowship award always overshadows the difficulties.

Treatment for displaced closed midshaft clavicle fracture



Non-operative treatment of closed midshaft clavicle fracture

Syah Bahari

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Until recently, treatment for closed clavicle fracture had been a conservative approach by means of either immobilization in a broad arm sling or figure of eight sling. However, recent evidence suggests that open reduction and internal fixation has become the preferred treatment option.

Nordqvist et al [1] looked at 225 consecutive patients, of which 197 with fracture of the midshaft of clavicle that were all treated conservatively with a figure of eight splint for three weeks. The remaining patients were allowed early range of motion as tolerated. They found that, after an average 17 years after injury, 185 patients were asymptomatic. The final clinical outcome of 39 patients was rated as fair and one patient was rated poor. The authors concluded that only a few patients with fracture of midshaft clavicle require operative treatment.

However, in order to compare the two treatment modalities, one needs to compare the main advantages and disadvantages of each treatment.

For conservative treatment of closed midshaft clavicle fracture, the main issue is the risk of non-union.

Studies by Neer [2] and Rowe [3] in the 1960s showed that the risk of non-union through non-operative treatment was 0.1% and 0.8% respectively. Thus, it was accepted that displaced midshaft clavicle fracture could be treated satisfactorily non-operatively until a more recent study suggested that the risk of non-union is much higher than previously reported [4]. However, the question is what the characteristic of the fracture that can predict the risk of non-union is. A study most often quoted by the proponent of operative treatment for displaced midshaft clavicle fracture is by the Canadian Orthopaedic Trauma Society [5]. The study showed that in a randomised control trial the operative treatment for displaced closed midshaft clavicle fracture was superior to conservative treatment for fracture displacement or shortening of more than 2cm. However, the most recent Cochrane Database review suggests that, although the evidence does favour surgical intervention, the available evidences are still limited and suggest the treatment option should be individualised [6].

Also, a recently published online survey on the treatment of closed midshaft clavicle fracture among Dutch trauma surgeons did not come to a definitive conclusion where conservative treatment was favoured for displaced fracture while operative treatment was for comminuted fracture [7].

The surgical treatment option is also not without its complications. A study by Leroux et al [8] showed that nearly every 1 in 4 patients treated with operative intervention had repeat surgeries ranging from implant removal, deep infection, non-union, pneumothoraces and malunion. The study also suggested surgeons' experience matters, where less experienced surgeons are likely to encounter more complications.

Finally, there is cosmesis, a topic rarely discussed by us orthopaedic surgeons but that does matter to patients. This is a very subjective matter and what is accepted in terms of cosmesis is debatable. Also, other subjective outcomes such as numbness over the operative site, prominent implant and the need for surgical removal of implant are factors that need to be fully discussed with patients when offering them operative treatment options for closed midshaft fracture of the clavicle.

In the right patient, non-operative treatment will likely yield similar results to operative treatment without the risk associated with operative intervention.

Operative treatment of closed midshaft clavicle fracture

Mohd Yazid Bajuri SICOT Active Member – Kuala Lumpur, Malaysia

The treatment paradigm for closed midshaft clavicle fracture has changed from conservative to operative intervention. The exponent for operative intervention is due to reduced incidence of non-union, malunion and better functional outcome.

From our own experience, we conducted a study on functional outcome of patients with closed midshaft clavicle fracture treatment by non-operative treatment [1]. From a series of 70 patients treated, we found that nearly half of the patients had impairment of shoulder function. We also concluded from the study that factors which predict a poor outcome from non-operative treatment are fracture comminution, fracture displacement of more than 21mm, and shortening of more than 15mm. Malunion and non-union of clavicle fracture were also correlating with poor functional outcome.

Our results were also similar to a study by Hill et al where they reported an increase in the incidence of non-union in displaced clavicle fractures which were correlating with reduced functional outcome [2].

A landmark study by the Canadian Orthopaedic Trauma Society [3] is a multicentre randomised controlled study between non-operative treatment compared to operative treatment for displaced closed midshaft clavicle fracture. This study showed a superior outcome of operative treatment to non-operative treatment in terms of time to radiographic union (16 weeks vs. 28 weeks) and significantly improved the functional outcome score (Constant and DASH) at all times during the period of the study. The main complication of the operative group was prominent implant, but arguably, with the advent of anatomical low profile locking plate, the need for implant removal can be avoided.

Similar outcomes were also reproduced by other randomised controlled studies comparing operative to non-operative treatment of displaced, closed midshaft clavicle fracture. Kulshretha et al [4] conducted a prospective cohort study of 73 patients. The non-operative group had 29% of non-union, 36% symptomatic malunion compared to no non-union and 4% symptomatic malunion respectively for the operative group. A more recent study is by Robinson et al [5]. They published a multicentre, randomised controlled trial of 200 patients where there was a significant reduction in the incidence of non-union in the operative group with a significantly better functional outcome score compared to the non-operative group.

However, there is still an indication for non-operative treatment of midshaft clavicle fracture. Midshaft clavicle fracture without significant comminution, shortening or displacement is not recommended for the operative treatment. Paediatric and low-demand patients are likely to do well with the non-operative treatment.

References can be found at: news.sicot.org/?id_page=905







Interview with Eva Pontén

Ratna Johari SICOT Associate Member & SICOT Young Surgeons Committee Member – Mumbai, India

In this edition of the SICOT Newsletter, we have the privilege of profiling Dr Eva Pontén. In the interview that follows, Dr Pontén will present a feminine perspective of a career in orthopaedics. She is a sought after widelv speaker internationally for her work in paediatric orthopaedics and hand surgery. A popular figure, one can often catch Dr Pontén exuding dynamism and enthusiasm, while multiple juggling lectures at numerous conferences.



Dr Eva Pontén, orthopaedic surgeon at Astrid Lindgren Children's Hospital, Karolinska Institute

Dr Pontén specialised in orthopaedic surgery in Sweden in 1995, followed by a specialisation in hand surgery in 1997. She also obtained a PhD in 2004 from the Umeå University. Since February 2001, she has been appointed to the Department of Paediatric Orthopaedic Surgery, Astrid Lindgren Children's Hospital, Karolinska Institute, in Stockholm.

Since 2007, she is also a member of the PhD Committee at the Department of Women's and Children's Health, Karolinska Institute.

Below are some of her reflections from a career spanning over 20 years...

What are your current roles and responsibilities?

I am an orthopaedic surgeon and hand surgeon at Astrid Lindgren Children's Hospital at Karolinska University Hospital, and team leader for the limb deficiency, arthrogryposis, spina bifida, DDH and cerebral palsy teams. A large part of my workload is also trauma. For the Karolinska Institute I also teach residents, medical students, physiotherapy students, and occupational therapy students. I have a muscle tissue research lab close to the clinic with a PhD student, a postdoc and a researcher, where we perform research on spastic muscle with the aim of solving the question – what actually does cause muscle contracture?

Why did you choose medicine and in particular orthopaedics?

I took a gap year after high school and worked at the hospital as a nurse's aide at both the Emergency Department and the Department of Obstetrics and Gynaecology and realised that working as an MD would be extremely interesting. During my medical studies and internship, I found orthopaedic surgery was really fun and interesting – fixing fractures and malformations gives instant satisfaction and fulfilment. After each workday you feel that you have accomplished something substantial. Most importantly, I found that the orthopaedic surgeons laughed a lot and seemed to have a great time at work!

You chose an unconventional career. What were the reactions you faced?

I was the first female resident both at the Department of Orthopaedic Surgery and at the Department of Hand Surgery. The chiefs and my fellow surgeons were both happy that I was there. Some said that my female presence 'made the culture at the department friendlier' and 'cheered them up'. However, sort of as in sports, I always felt that I was running the female class on the side, and that few thought of me as competing in the same group as my fellow male residents. I was the woman at the department, representing all women. So I have had to set my own goals.

What have been the challenges in your early days and how did you cope with them?

Being one of the first female orthopaedic surgeons in a culture where older male surgeons would choose a protégé more similar to themselves made me realise that I needed to travel to learn from internationally respected surgeons around the world. Observing at different hospitals around the world has given me a unique and very valuable knowledge both about orthopaedic surgery and about how we as orthopaedic surgeons can deal with the difficulties patients and their families are facing after trauma or after they have been informed that their child is diagnosed with a very severe and perhaps life threatening disease.

What have been the biggest hurdles of your career so far?

When I was a young female orthopaedic surgeon it was difficult to be perceived as one of the 'guys' when it came to being 'invited' to the bigger surgeries. I overcame this by studying hard and taking my own initiatives.

What homework goes into doing the miraculous surgeries you do?

Know your anatomy, dissect carefully, read about the surgeries and visit experienced orthopaedic surgeons to learn.

What must the young surgeon do in order to be competent in his or her field?

Study hard, do as much surgery as you can, and visit other centres to learn. Have a research project that has something to do with your clinical work. It will teach you how to evaluate scientific references and it will give you a deeper understanding of the disease or injury and how the orthopaedic treatment will affect your patient.

A few pearls of wisdom you have gained over your illustrious career...

If the family doesn't work, nothing works (i.e. spend time with and take care of your family – this will reward you both in the short term and in the long term).

We all have our ups and downs – wait and see – things will get better.

Never give up. If you encounter an obstacle or difficulty you can either go through it or around it. Both ways may work.

Everyone wants to do good in some way.

Having a baby will take both energy and time, which your male colleagues won't experience to the same extent when they become fathers. So, in a short-term perspective, you might experience that you are 'behind' your male colleagues. However, having a baby will give you so much wisdom and also practical skills that you will use in your profession. And you will get ahead again later on. Male surgeons will also have certain times of low professional productivity in their lives.

Your thoughts on work/life balance...

Two of my children were born during my medical studies, one during my internship and one during my specialisation. Their father and I shared the one-year maternity/paternity leave per child that we get here in Sweden. We then found an excellent daycare nursery that we trusted immensely; we were never worried during work. Weekends and evenings after work we spent with our kids. I enjoyed that time so much, and it was a true pleasure to be home now and then. Also, my mother often came and helped out, so now they have a close relationship. Now that all my children are grown up, it is very important for me also to socialise with people who are not working at the hospital, and with family and friends. It makes me happy, and when I am happy I work better and more efficiently.

So, get as much help as you can so that you can enjoy time with your kids! Remember to socialise with people outside the hospital and prioritise family and friends – they will help you a lot when things get rough at work.

Why do you think so few women choose a career in orthopaedics? What can be done to improve the numbers?

The most important thing is to feel welcome and be part of the group. When everyone says 'orthopaedic surgeon' without the prefix 'female' we have come a long way. So just by not dividing up orthopaedic residents and surgeons by what sex they are, I believe it is easier to recruit the best orthopaedic resident, irrespective of their gender.

I believe, and hope, that things are now much different from when I started my career. Currently, at my department, there are 50% female orthopaedic surgeons. The male orthopaedic surgeons are at home with their children just about as much as the female orthopaedic surgeons. Female surgeons are perceived as individuals, just as male surgeons always have been.



Your guide to the SICOT Diploma in trauma and orthopaedics

Sherif Elnikety Kent, United Kingdom

Sherif Elnikety, one of the top two candidates of the 2012 SICOT Diploma Examination, has written the following article explaining how best to prepare for, take and succeed at the international trauma and orthopaedics exit exam. This article originally appeared in the January 2015 issue of the Bulletin of the Royal College of Surgeons. The article can be viewed and downloaded at: bit.ly/sicotdip

What is the SICOT Diploma?

The SICOT diploma is an exit examination for trauma and orthopaedics at the level of general specialist surgeon. It is an international exam and was held for the first time in 2003 during the SICOT Orthopaedic World Congress (OWC) in Cairo. It has been running every year since then in line with the SICOT OWC. The Congress usually takes place in October/November and the exam usually runs for two days, just prior to the OWC, in the same centre for the Congress. The first day is for the written part and the following day is for the oral examination. The diploma targets surgeons qualified in countries that do not run an exit examination or whose local exit exam is not widely recognised. Some surgeons sit this exam as preparation for a more difficult exit exam in their countries, such as the FRCS (T&O) examination in the United Kingdom.

I was informed by a senior member of the SICOT Education Committee that active discussions are taking place with individual organisations worldwide to obtain formal recognition of the diploma. Unfortunately, to date, there is no information available regarding the recognition of the SICOT diploma in individual countries. I expect the recognition of the diploma and specialist registration will be granted on an individual case basis by the local organisations.

Exam requirements

The requirements to sit the examination are at least four years of postgraduate experience and a letter from the head of your department confirming your experience and competence to sit the exam. The application deadline is usually by the end of February each year and you will be notified of your acceptance/refusal by the end of March. In recent years, there have been more applicants for the exam than places available. The SICOT Head Office therefore runs a waiting list each year. You can choose to stay on the waiting list in case a space becomes available. I was on the waiting list for the 2012 exam.

Registration and fees

Once you are accepted to sit the examination, you will receive an email inviting you to register and pay the fees. The fees in 2012 came to a total of EUR 800 for the two parts. Registration for the diploma is separate to the OWC registration; you will have to register for the OWC separately and pay the Congress fees if you are interested in attending the Congress. Usually, the SICOT Head Office will notify you with the final details a few weeks prior to the exam.

Preparation

As with other exit examinations, preparation starts on the first day of your orthopaedic training and is consolidated during the final few months prior to the exam. Before applying you should ask yourself: Am I ready for the exam? Is it the right time?

The purpose of the SICOT diploma is to qualify you as a specialist; it examines your general orthopaedic knowledge and it is unlikely that you will pass unless you have enough orthopaedic experience. The level of knowledge tested is that expected from a surgeon with at least 3-4 years of general orthopaedic practice.

You need around six months of condensed preparation for the examination. You should bear in mind that both parts of the exam (written and oral) are sat on consecutive days, unlike other exams where you have a few months in between. This means your preparation should target the two parts at the same time. At this stage, the use of textbooks should be mainly for reference and your efforts should be directed toward practising multiple choice questions (MCQs) and mastering your viva techniques.

The written part

The written part of the examination consists of 100 MCQs during 2 hours. It is a paper-based exam and is usually run in a large hall to accommodate all the candidates. You will be provided with the necessary papers and pencils.

The Hyperguide website (www.ortho.hyperguides.com) question bank was the main source of questions until 2012 [1], although this no longer appears to be the case. Nevertheless, the Hyperguide question bank is an important preparation tool with nearly 4,000 MCQs. It fits the level of knowledge needed for the SICOT diploma.

In preparing for the examination, you should go through as many MCQs as you can, as well as studying a review book. For the SICOT exam (and indeed for similar exit exams), previous candidates have recommended Miller's *Review of Orthopaedics* [2], the AAOS Comprehensive Orthopaedic Review package by the American Academy of Orthopaedic Surgeons (which contains a volume with MCQs as well) [3], and the Postgraduate Orthopaedics series by Banaszkiewicz et al [4,5]. The choice of which books to use is yours and should be based on what you find easiest to digest.

The oral part

The oral part of the examination is held in a large hall with multiple stations. You will rotate around four stations, each for 30 minutes, shared between two examiners per station. Candidates are divided into several groups for the oral exam day, and you should expect to know your group and your starting time a few days before the exam. The stations comprise adult orthopaedics, hand surgery and paediatrics, trauma, and basic science.

The order of the stations will vary according to the exam organisation. It is very well organised; you will be told at which station to start before entering the hall and you will be guided by the examiners while rotating between stations. A bell will ring to indicate the beginning of each station session and halfway through (at 15 minutes) the bell will ring for the examiners to switch. Although it is not compulsory, it is traditional to present for the oral part in a formal suit, whereas comfortable clothes are advisable for the written exam.

The oral exam can consist of either a long discussion about one topic or brief discussions about several topics. At my adult orthopaedics station, the first examiner asked me about shoulder arthritis in a young rheumatoid patient, going through presentation, investigation and treatment options. The second examiner guizzed me on a sports knee injury, again going through all aspects of clinical presentations, investigations and treatment options. At the trauma station, the first examiner presented me with clinical imaging of multiple limb injuries on his laptop; assessment, classification and treatment were discussed. The second examiner was more interested in spinal trauma, and therefore focused on spinal magnetic resonance imaging, X-rays and clinical imaging. The paediatric and hand surgery examiners also used imaging on a laptop to examine the extent of my knowledge. At the basic science station, the examiners skipped through a few topics, examining my knowledge in each topic.

Overall, at least 50% of the questions asked in the written and oral parts are about common orthopaedic conditions. You should prepare yourself for in-depth questions about these.

Results

The results are announced on the following day and a diploma certificate is handed out at the Closing Ceremony of the OWC. The German section of SICOT funds travelling fellowships for a period of four weeks to four orthopaedic centres in Germany. This award is granted to the top two performing candidates each year.

As a final piece of advice, if you are flying from a distant country then you should arrive in the hosting country early to get used to the local time zone and overcome jet lag. Always check the local weather and be well prepared. Good luck!



References can be found at: bit.ly/sicotdip

Paediatrics

Prepared by Mohamed Sukeik

SICOT Associate Member & SICOT Newsletter Editorial Board Member – Harlow, United Kingdom

- 1. Risk factors for Developmental Dysplasia of the Hip (DDH) include all of the following except:
 - a. Breech positioning
 - b. Male sex
 - c. Positive family history
 - d. Being first-born child
 - e. Decreased intrauterine space
- 2. In newborns and infants up to 6 months of age diagnosed with developmental dysplasia of the hip, which of the following treatment options is most appropriate?
 - a. Application of a Pavlik Harness
 - b. Closed reduction and application of a Pavlik Harness
 - c. Closed reduction and application of a hip spica
 - d. Open reduction
 - e. Open reduction and application of a Pavlik Harness
- 3. What is the major risk associated with both open and closed reductions in developmental dysplasia of the hip?
 - a. Vascular injury
 - b. Nerve injury
 - c. Pain
 - d. Stiffness
 - e. Infection
- 4. Which zone of the growth plate is affected in Achondroplasia?
 - a. Zone of Maturation
 - b. Zone of Provisional Calcification
 - c. Reserve Zone
 - d. Hypertrophic Zone
 - e. Proliferative Zone
- 5. Which zone of the growth plate is affected in Ricketts?
 - a. Zone of Maturation
 - b. Zone of Provisional Calcification
 - c. Reserve Zone
 - d. Zone of Degeneration
 - e. Proliferative Zone
- 6. Which zone of the growth plate is affected in Acute Haematogenous Osteomyelitis?

- a. Primary Spongiosa
- b. Hypertrophic Zone
- c. Reserve Zone
- d. Secondary Spongiosa
- e. Proliferative Zone
- 7. The Centre Edge Angle (CEA) of Wiberg measurement is useful for the assessment of which condition?
 - a. Slipped upper femoral epiphysis
 - b. Perthes disease
 - c. Developmental dysplasia of the hip
 - d. Adolescent idiopathic scoliosis
 - e. Supracondylar fracture of the humerus
- 8. Which of the following congenital hand anomalies require removal of supernumerary digits and is commonly called mirror hand?
 - a. Triphalangeal thumb
 - b. Ulnar dimelia
 - c. Apert syndrome
 - d. Postaxial polydactyly
 - e. Camptodactyly
- 9. Which of the following congenital hand anomalies require removal of supernumerary digits, rarely occurs as a solitary deformity and is usually associated with complex syndactyly?
 - a. Central polydactyly
 - b. Bifid thumb
 - c. Clinodactyly
 - d. Preaxial polydactyly
 - e. Congenital ring syndrome
- 10. Which of the following congenital hand anomalies require removal of supernumerary digits and is further subdivided into 3 groups according to the Stelling and Turek Classification?
 - a. Ulnar dimelia
 - b. Apert syndrome
 - c. Postaxial polydactyly
 - d. Camptodactyly
 - e. Bifid thumb

Answers are published at: www.sicot.org/e-newsletter-73-exam-corner



Report of the Würzburg SICOT Orthopaedic Fellowship

Tarek Fetih SICOT Associate Member – Assiut, Egypt

I am glad to report about my successful completion of the Würzburg SICOT Orthopaedic Fellowship. I have to say it was a unique experience in my career. I had the chance to spend six months (from May to October 2014) in the *Orthopädische Klinik im König-Ludwig-Haus,* Würzburg, Germany, where I could monitor and participate in the everyday work at one of the top rated arthroplasty centres under the kind supervision of Prof Maximilian Rudert. A large part of my interest was also focused on foot and ankle surgeries and I could work extensively with Dr Matthias Walcher.

Owing to this fellowship, I have attended a large number of arthroplasty surgeries including primary hip, knee and shoulder replacement in addition to one- and two-stage revisions. The hospital is classified as a maximum-care centre for arthroplasty surgeries, occupying first place all over Germany in revision joint replacement and dealing even with the most difficult revision situations.

In the spectrum of foot and ankle surgeries I have participated in foot and ankle trauma surgeries, ankle cartilage reconstruction surgeries, formal and arthroscopic-assisted ankle fusion, primary and revision ankle replacements, hindfoot osteotomies, peroneal and posterior tibial tendons surgeries, arthroscopic treatment of anterior and posterior ankle impingement, Achilles tendon surgeries, diabetic foot surgeries and hallux surgeries.

The most frequent and distinguished foot and ankle surgery done in the hospital is the articular surface reconstruction for osteochondral lesions of the medial talar dome, where ankle arthroscopy is done first to inspect the joint, evaluate the lesion and prepare the crater. Then, the defect is approached via a medial malleolar osteotomy and the articular surface is restored by collagen membrane fixed with fibrin glue. I also enjoyed the arthroscopic-assisted ankle fusion for non-deformed arthritic joints which saves the patient the relatively large incision of the open technique and allows almost complete preparation of the fusion surfaces and, by the addition of three percutaneous compression screws, a very high union rate can be guaranteed. Being a fellow in this hospital gives you also the chance to keep in close contact with the patient management in a wide variety of other orthopaedic subspecialties such as sports injuries of the knee and shoulder, paediatric orthopaedics and spine.

I also had the opportunity to attend the weekly morning meeting to discuss the operative lists for the entire week, in addition to attending some anatomic dissection sessions at the university lab. I found both to be great occasions for rich scientific interaction.

At König-Ludwig-Haus, all the doctors and other staff members were very kind to me and very cooperative. Now I can understand the guidelines for management of orthopaedic patients according to the German standards. The operative theatre system, instruments and infrastructure at the hospital will definitely influence my future practice of orthopaedic surgery.



Dr Tarek Fetih and Prof Maximilian Rudert

Prof Rudert was the perfect host to me and took care of making my stay ideal. He is a very generous man, as well as a talented and highly experienced surgeon, who always greeted us with a smile on his face.

I would like to thank SICOT for the opportunity to learn from a highly qualified surgical team and enjoy the amazing city of Würzburg.





36th SICOT Orthopaedie World Congress

17-19 September 2015 Guangzhou, China

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