



SICOT

Newsletter

SICOT Project “Let’s Pledge to Give”



In this issue

- **Editorial:** SICOT Project – “Let’s Pledge to Give”, by S. Rajasekaran 2
- **Expert Corner:** The Sinus Tarsi Approach in Displaced Intra-Articular Calcaneal Fracture 3
- **Training Around the World:** Orthopaedic Training in Greece 6
- **Case of the Month:** Management of Osteolysis and Component Loosening in a Hybrid Total Hip Replacement 7
- **Scientific Debate:** Approach to Total Hip Replacement: Have We Reached Consensus Yet? 8
- **Course Appraisal:** Hull Deformity Course SICOT Award 10
- **Fellowship News:** 2016 TCH/SICOT Research Fellowship Report 11
- **Congress News:** 38th SICOT Orthopaedic World Congress, Cape Town – Welcome Message from Doron Frantzen 12



SICOT Project – “Let’s Pledge to Give”

S. Rajasekaran
SICOT President – Coimbatore, India

Dear Members,

Greetings from SICOT.

SICOT is the largest and truly International Orthopaedic Association of the world with members from nearly 127 countries. I am glad that our Society is growing from strength to strength. Our annual meetings are improving steadily not only in attendance but also in quality and standards. Although the primary aim of SICOT is to promote academics and learning amongst its members, it should also serve as a vehicle to carry the best of modern orthopaedic surgery to those who deserve it most. It would be fruitless if we improve in academics and techniques but the benefit does not reach the patients who need it. The rich expertise and experience of SICOT members should reach those who deserve the best of orthopaedic care but who cannot afford it.

Towards this end, I propose that SICOT initiates the project – “Let’s Pledge to Give”, where every SICOT member would be encouraged to offer his/her expertise free of charge to at least one deserving patient every year. The motto will be “Be a blessing to one patient this year”. This will be a novel programme that will increase the value of SICOT to the society around the world and will also have a tremendous public relations value.

The logistics and economics of health care delivery are very different in different parts of the world and hence the modus operandi of this project will have to be different in different regions. In many European countries like Germany and Scandinavian countries, free health care delivery is accessible to all and so this programme may have less impact. However, in most countries of Asia, Africa and Latin America the applicability of this programme is real and huge. Every day, surgeons in these countries come across patients with severe orthopaedic problems often at the end stage of the natural history of the disease, neglected mainly because of lack of resource or insurance cover. There is a great opportunity for SICOT members to make a real change in the lives of such patients.

Surgeons worldwide seek opportunities to do charity and philanthropy travelling across the world. However, this is neither time nor cost effective. This programme is unique in that it will allow surgeons to perform charity at their place of work in their day to day practice. The scope of charity can range from just ‘surgery free of surgeon’s fees’ to ‘entire treatment being free’. Many surgeons work in circumstances where they can exert a significant influence in the hospital set-up where they have worked for many years. They may be able to negotiate a free service for one or two patients every year.

Scope of ‘Charity’

As there is a wide variation in the health care delivery model across the world, the scope of charity will also have to vary. This will include:

1. **The entire treatment free** – This will be applicable to a majority of countries in Asia, Africa, Latin America and even some countries in Europe. Here all charges including hospitalisation, surgeon’s fees and implants will be made free. Obviously this is very challenging to the surgeon and can be done only in scenarios where the surgeon has a significant influence in the setting of his practice. Many SICOT members are practising in hospitals for many years and have contributed immensely to the growth of the institutions. They are quite influential with the management of the hospital and have considerable say with the industry people. It would be possible for them to have permission from their administration to waive charges for just one patient a year. They can also involve industry partners who may willingly provide an implant or prosthesis for one case every year. In every country, there are many social service organisations such as the Rotary, Round Table, and so on, who may also be enthusiastic partners and generate the required funds. In our experience a lot of partners can be generated once they know that the surgical team is willing to operate free.

(continues on page 5)



The Sinus Tarsi Approach in Displaced Intra-Articular Calcaneal Fracture

Tim Schepers
Amsterdam, Netherlands

Since the early nineties the Extended Lateral Approach (ELA) has been the workhorse in the treatment of displaced intra-articular calcaneal fractures. This approach is however hampered by a high percentage of (costly) wound complications [1-4]. There is some evidence suggesting that infectious complications lower overall outcome following the surgical treatment of calcaneal fractures [5]. It is therefore of paramount importance to lower the risks of wound complications.

By combining a less invasive open approach at the level of the talocalcaneal joint with percutaneous reduction of the tuber excellent reduction of the posterior facet and good restoration of overall anatomy (height/width/axis) can be obtained.

The Sinus Tarsi Approach (STA) has regained interest after the article by Ebraheim et al [6]. Since that time several case series and a handful of prospective (randomised) trials have been published on this topic [7-11]. Common findings are a strong reduction in the number of wound complications, similar reduction in anatomy and joint congruity, and at least a similar outcome [12,13]. The wound complications are usually minor and easily treated with conservative measures. Re-operation with wound debridement was needed only in a few cases. No need for (free) flap coverage has been reported as the wound is always closable by primary or secondary intention.

The rate of secondary arthrodesis is similar as in the series treated through the ELA. An additional benefit is that the incision for a secondary subtalar arthrodesis is the same (sinus tarsi) incision as for the initial fracture management.

Starting from 2013 we introduced the STA in our hospital, which rapidly became our primary technique with almost 150 cases in the last three years. Below I will describe our preferred technique in the treatment of displaced intra-articular calcaneal fractures via the sinus tarsi approach in a step-by-step manner. Additional key images are provided (selected images from different patients).

Surgical technique

- Following general anaesthesia, the patient is lying on a bean-bag on the contralateral side. The affected leg is in flexion and elevated using the bean-bag (Figure 1).



Figure 1 – Perioperative view of positioning, the sinus tarsi approach and post-operative coverage

- The C-arm approaches from the opposite side.
- An ankle-block is given using 20cc (Levo-)Bupivacaine at all five nerves approximately 5cm above the ankle joint. In most patients this ensures enough pain relief immediately post-surgery, at which time they start oral analgesics.
- Depending on the surgeon's preference a tourniquet is placed on the lower limb a hand-width below the knee-joint. Depending on the systolic blood pressure it will be inflated between 200 and 250 mmHg during the reduction of the joint (approximately 30 to 45 minutes).
- An incision (sinus tarsi approach; STA) is made from the tip of the distal fibula towards the base of the fourth metatarsal. It is usually between 3 and 4 cm.
- The peroneal tendons are protected and held plantarwards. The sural nerve is not explored, but if encountered it is freed up and protected.
- The canalis tarsi is debrided by removing Hoke's fat and ligaments between talus and calcaneus.
- With a broad periosteal elevator the brittle lateral wall and soft tissues are separated.

- A small distractor with 2.5/3.0 half-pins is subsequently mounted on the fibula (above the tibio-talar joint line) and on the distal part of the tuberosity of the calcaneus. The pin placement is adjusted for any varus/valgus malalignment.
- A 1.6mm K-wire is inserted from plantar through the medial sustentaculum part of the fractured calcaneus and driven into the talus to create a constant/fixated part medially.
- By increasing distraction the tuberosity is brought downwards and space is created in the posterior talocalcaneal joint. When the fracture is older than 1-1.5 weeks the primary fracture lines sometimes need to be released with small osteotomies.
- Depending on the type of the intra-articular fracture (Joint-depression; JD or Tongue-type; TT), different reduction manoeuvres are employed.
- In case of a JD fracture, with the use of a small bone rasp and a small K-wire introduced through the STA as a joystick, the depressed fragments are lifted against the talus and fixated towards the medial constant fragment. Sometimes additional K-wires from plantar are needed to stabilise these fragments prior to definitive fixation. In case of multiple intra-articular fracture-lines one works from medial towards lateral. Reducing the lateral joint fragment last. This should restore Böhler's angle.
- In case of a TT a 2.5-3.0mm half-pin is introduced from posterior to lever the fragment in place. Often aided with a small bone rasp or Howard elevator via the STA. Reduction of the joint can be observed via the STA and using an image intensifier.
- With the foot in neutral position a lateral view can be obtained, when lifting the forefoot (toes higher than the heel) a Brodén view is made. With the patient on the contralateral side, by extending the leg, externally

rotating at the hip and lifting the forefoot further an axial view can be obtained by aiming the C-arm at 45 degrees towards the sole of the foot.

- Subsequently the anterior process and Gissane's angle are assessed.
- At this stage a decision is made whether joint reconstruction is feasible. If the fracture is likely to require secondary arthrodesis in the future (Böhler's angle below zero degrees, open fractures, Sanders type 4, locked fracture dislocations) a primary arthrodesis has been discussed with the patient pre-operatively as part of the shared discussion making process.
- In case of a primary arthrodesis the cartilage is removed from the subtalar joint and three 7.3 cannulated screws are added to the fixation of the calcaneal fracture (Figure 2).



Figure 2 – Example of a severe displaced intra-articular calcaneal fracture treated with a primary arthrodesis following reduction through a sinus tarsi approach

- Following anatomical reduction of the joint and temporary K-wire fixation of the calcaneus the lateral wall is reduced.
- Now either screw fixation can be performed or a small plate is introduced via the STA. Both methods are combined with longitudinal percutaneous screws from posterior (Figure 3).

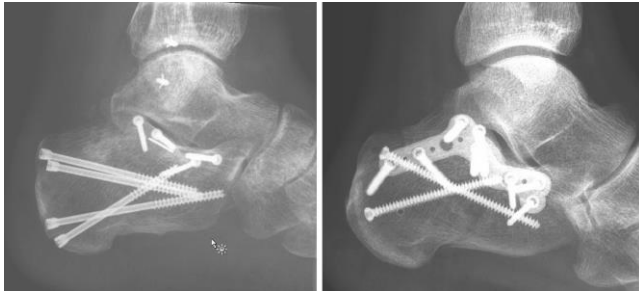


Figure 3 – Two examples of different fixation methods following reduction

- A bone filler is rarely used to fill the cavity of the neutral triangle.
- After rinsing the wound, it is closed in layers, with the skin closed with either Donati sutures or a running locked skin closure. Either a pressure bandage for 3 days or a negative pressure wound dressing is applied for 1 week (only in high risk wounds). After this period people are allowed to change the dressings themselves on a daily basis.
- No plaster is used, patients are allowed to exercise the ankle joint as soon as possible. Most patients (without additional injuries) are released from hospital the next day.
- Patients stay non-weight bearing for 8 weeks, after which new radiographs (lateral, axial, Brodén views) are obtained. In case of sufficient fracture healing patients are allowed to gradually increase weight bearing.
- Patients are well informed about the total recovery time of a displaced intra-articular calcaneal fracture, which may take up to 1-1.5 years.

References can be found at:
www.sicot.org/enewsletter-81-expert-corner



Editorial (continued from page 2)

SICOT Project – “Let’s Pledge to Give”

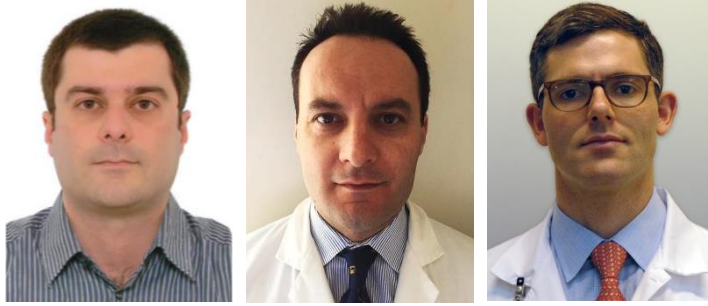
2. **Surgeon’s charges free** – There are health care models where the surgeon may not be able to obtain a complete waiver of the hospitalisation and the implant charges. Sometimes, the patient’s insurance cover may not allow a high-cost complex surgical procedure to be performed. In such scenarios, it would still be a great help to the patient if the surgeon’s charges can be made free. Very often, the surgeon’s charges range from 20 to 40% of the entire cost and subsidy of this may help the poor patient substantially.

When do we start?

The kick-off date will be 1 January 2017. Each SICOT

member can operate one or more patients free and communicate it to the SICOT Head Office. The SICOT website will have an area accessible to members where such free surgeries are registered. The pre- and post-operative pictures of patients can be loaded on our website and publicised in our newsletter and online journal. This will act as an incentive for other SICOT members also to do the same.

I thank you in advance for your enthusiastic support for this project. I believe that most of the SICOT member surgeons are already performing many charitable surgeries. I hope that this project allows us to make SICOT more useful to society.



Orthopaedic Training in Greece



*Vasileios Soranoglou, Lazaros Poultsides & Alexander McLawhorn
New York, United States*

“It is impossible for someone to know medicine, unless he knows exactly what human is”. This is a quote from Hippocrates, the father of medicine, and delineates the true deep meaning and mission of medical science throughout the centuries. In ancient Greece, Hippocrates first described treatments for dislocations and infections complicating fractures. The Hippocratic School and, later on, Galen formulated the theories which dominated medicine up to the beginning of the 18th century. The Greeks were the founders of rational medicine in the golden age of Greek civilization in the 5th century B.C. [1]. Thus, it is not surprising that nearly three-fourths of medical terminology is of Greek origin. For example, “orthopaedics” is a compound word deriving from the Greek words “*orthos*” (meaning correct or straight) and “*paidion*” (meaning child).

Nowadays in Greece, after graduating from high school, participating in Panhellenic exams is mandatory for any student desiring admission to a university. Specifically, admission to a medical school requires very high grades. Competition for medical school admission is fierce, since there are only seven university medical schools in Greece and all of them are public. These are located in Athens, Thessaloniki, Patra, Larissa, Ioannina, Crete and Alexandroupoli. Thessaloniki also hosts a Military Medical School. All medical school curricula encompass 12 semesters, requiring at least 6 years of attendance, divided into 3 preclinical years and 3 clinical years. After successful completion of medical school, graduates are granted their licence to practise medicine. In Greece, all university hospitals and general public hospitals, along with some specific military hospitals, meet the requirements for accredited residency training programmes. Each residency applicant applies for residency based on his or her specialty-of-choice and hospital preference. Depending on individual availability and demand, the applicant may have to enter a waiting list until a residency spot becomes available.

Orthopaedic residency programmes last 6 years and are divided into three parts: a) 1 year of internship in General Surgery primarily emphasising traumatology; b) 1 year of Paediatric Orthopaedic Surgery; and c) 4 years of Adult

Orthopaedic Surgery. During the latter 4 years, residents have the option of rotating for one semester each, and for maximum 1 year in total, in other medical specialties (Neurosurgery, Intensive Care Medicine, Vascular Surgery, Plastic Surgery) or Orthopaedic subspecialties (Hand and Upper Extremity, Spine, Oncology, and Sports Medicine) [2]. Based on interest and availability, one can complete his or her education in different hospitals.

During their training programmes, Orthopaedic residents participate in trauma and elective operations, rotate in outpatient clinics, and are involved in patient management both in the emergency department and inpatient Orthopaedic wards. Residents work on average 70 to 85 hours per week, including 6 to 8 24-hour shifts per month both in the emergency and inpatient settings. Each Orthopaedic Surgery department along with its educational programme usually holds a morning conference, during which all trauma and in-patient cases are presented and thoroughly discussed. Moreover, the College of Hellenic Orthopaedic Surgeons organises lectures and workshops on a weekly basis fostering Orthopaedic education and academic exchange across the country.

Following completion of the residency programme, exams are held every 2 months in order to become board certified in Orthopaedic Surgery. Successful completion of the written exam is required to proceed to the oral exam. During the oral exam, a 3-member committee including at least one Professor evaluates the candidate. If a candidate fails 3 consecutive times, he or she must repeat 6 months of residency without compensation.

As a prerequisite for the board certification exams, a candidate must complete 1 year of mandatory rural practice in the primary health care system. This can be done either before, during or after completing residency training [2]. The Orthopaedic Surgery certification entitles someone to practice Orthopaedic Surgery in both the private and public health care systems, and it is fully recognised in all European countries.

References can be found at:
www.sicot.org/enewsletter-80-training-around-world



Management of Osteolysis and Component Loosening in a Hybrid Total Hip Replacement

Alexander S. McLawhorn & Peter K. Sculco
New York, United States

Case Presentation

A 56-year-old gentleman, who had undergone a left total hip arthroplasty (THA) eighteen years ago for failed slipped capital femoral epiphysis (SCFE) pinning, presented with increasing pain in his left hip and thigh over the last three years. He had a significant decline in his function over the last year. He ambulated with crutches and was unable to bear weight on the left leg. He had become essentially immobile from his condition. He denied fevers or chills and had no rest or night pain. He took narcotic analgesics for pain control daily.

His past medical history was significant for hypertension and insulin-dependent diabetes mellitus, complicated by bilateral lower extremity neuropathy and stage IV chronic kidney disease. His medications included anti-hypertensives, oral anti-hyperglycemics and insulin, and gabapentin. He had no allergies. He denied smoking and rarely consumed alcohol.

On physical examination, the patient was 193 cm tall and weighed 117 kg (body mass index, 32 kg/m²). He was unable to walk without crutches. Stinchfield testing was

negative, but he had severe pain with hip rotation. He had hip flexion of 90 degrees, external rotation of 50 degrees, internal rotation of 5 degrees, abduction of 30 degrees, and adduction of 10 degrees. He had normal power distally in the left leg and foot. His sensation to light touch was diminished distal to the knee. The skin was intact, warm and well-perfused distally, but there were no palpable pulses.

Standard plain radiographs (Figure 1A-C) demonstrated a hybrid left THA. Prior radiographs were reviewed for comparison. There was severe, progressive osteolysis around the femoral component, with a chronic osteolytic fracture of the greater trochanter. There was a cortical breach at the tip of the femoral stem posterolaterally, and femoral component migration indicative of loosening. There was eccentric polyethylene liner wear.

What are your next steps in management?

To read more, please go to:
www.sicot.org/enewsletter-79-signal-case

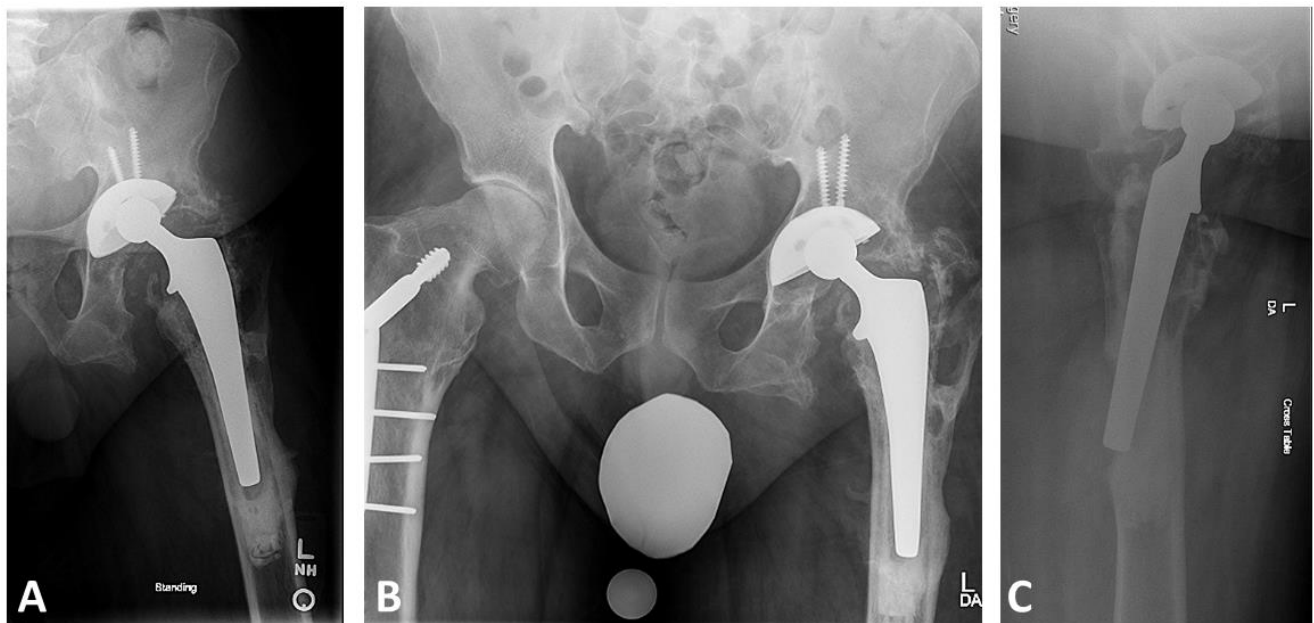


Figure 1



Approach to Total Hip Replacement: Have We Reached Consensus Yet?

Mohamed Sukeik & Fatih Kucukdurmaz

SICOT Newsletter Associate Editor – London, United Kingdom

& SICOT Young Surgeons Committee Chairman – Istanbul, Turkey

Total hip replacements (THRs) are among the commonest orthopaedic operations performed and the numbers are increasing due to an aging population [1]. According to the National Joint Registry (NJR) in the United Kingdom, more than 85,000 THRs were performed in 2014 [1]. Despite the overall high rates of satisfaction, a number of controversies remain surrounding the best surgical approach to be utilised for optimal outcomes [2]. The ideal surgical approach should provide excellent exposure to the acetabulum and femur with minimum violation of the surrounding soft tissues in order to reduce operative time, blood loss and post-operative pain, and enhance recovery. It should also be associated with low risk of complications such as periprosthetic fractures, neurovascular injuries, dislocations, infections, thromboembolism and revisions.

A number of surgical approaches for hip replacements have been described as the most common, including the posterior, direct lateral, anterolateral, transtrochanteric lateral and anterior approaches. We will briefly present the advantages and disadvantages of each approach and ask the question whether any of these approaches has gained popularity to become the ideal approach.

Posterior approach (Moore, Southern)

This is the most commonly used approach for THRs accounting for around 60% of cases in the NJR [1]. It was popularised by Moore and is often called the Southern approach [3]. It utilises no internervous planes. Structures at risk include the sciatic nerve and inferior gluteal artery.

Advantages:

1. Technically simple.
2. Does not violate the abductor mechanism.
3. Excellent exposure to both the acetabulum and femur.
4. Low rates of heterotopic ossification [4].

Disadvantages:

1. High dislocation rates reported as high as 9.5% in earlier studies [5, 6].
2. Potential for sciatic nerve injury.

Direct lateral approach (Hardinge)

Popularised by Hardinge [7], the direct lateral approach is the second most commonly used approach for THRs accounting for around 30% of cases in the NJR [1]. It also utilises no internervous planes as it relies on splitting the fibers of the gluteus medius, gluteus minimus and vastus lateralis [7]. Structures at risk include the superior gluteal nerve, femoral nerve, femoral artery and vein, and the transverse branch of the lateral circumflex artery of the thigh.

Advantages:

1. Better exposure to the femur for reaming than the anterolateral and anterior approaches.
2. Avoids the need for a trochanteric osteotomy whilst providing good exposure to the joint.
3. Minimal risk of sciatic nerve injury.
4. Low dislocation rates.

Disadvantages:

1. Violates the abductor mechanism which may result in abductors weakness and a Trendelenburg gait due to the detachment of the abductors or injury to the superior gluteal nerve.
2. Higher rates of heterotopic ossification than the posterior approach [4].

Anterolateral approach (Watson Jones)

This approach also utilises no internervous planes as it uses the intermuscular plane between the tensor fascia latae and gluteus medius both innervated by the superior gluteal nerve [8]. Structures at risk include the femoral nerve, femoral artery and vein, and profunda femoris artery.

Advantages:

1. Avoids the need for a trochanteric osteotomy if a partial detachment of the abductor mechanism is utilised to expose the joint.
2. Stability with less chance of posterior dislocation.

Disadvantages:

1. Exposure to the femur not as good as the posterior and direct lateral approaches which may result in damaging the femoral shaft and malpositioning of the femoral component. Additionally, in difficult exposures, further capsular release and release of the tensor fascia latae and sartorius may be necessary, increasing the risk of soft tissue injury and fractures. A trochanteric osteotomy in some cases may also be necessary.
2. Abductors weakness during dissection or injury to the superior gluteal nerve [9].

Transtrochanteric lateral approach (Charnley)

Charnley popularised this approach in 1962 with some centres still using it regularly especially for revision THR surgery [10, 11].

Advantages:

1. Good exposure to both the acetabulum and femur.

Disadvantages:

1. Non-union of the trochanteric osteotomy, pain, bursitis and wire breakage.
2. Prolonged operation due to the osteotomy and delayed rehabilitation due to delayed weight-bearing.
3. Reduced abductor power has been reported with trochanteric migration [12].

Anterior approach (Smith Peterson)

This approach utilises the internervous planes between sartorius (femoral nerve) and tensor fascia latae (superior gluteal nerve) superficially and rectus femoris (femoral nerve) and gluteus medius (superior gluteal nerve) deeply [13]. Structures at risk include the lateral femoral cutaneous nerve, femoral nerve and ascending branch of the lateral femoral circumflex artery.

Advantages:

1. The only approach which utilises an internervous plane.

2. Avoids the need for a trochanteric osteotomy in most cases whilst providing good exposure to the acetabulum.
3. Limited morbidity, early mobilisation and high stability with reduced dislocation rates [14].
4. Ability to use intraoperative radiographs as the patient is supine.

Disadvantages:

1. Exposure to the femur is not as good as the posterior and direct lateral approaches. Therefore, in difficult exposures, similar to the anterolateral approach, further capsular release and release of the tensor fascia latae and sartorius may be necessary, increasing the risk of soft tissue injury and fractures. A trochanteric osteotomy in some cases may also be necessary. A specialised table is used by some surgeons to facilitate femoral exposure.

The development of a number of approaches over time for THR surgery suggests that no single approach fits the description of the 'ideal approach'. This is evidenced by the advantages and disadvantages listed above for each approach. In fact, the debate on which approach is better remains a hot topic at almost every conference we attend, where surgeons with relevant experience of one approach try to present it as the ideal approach.

To read the concluding remarks and to see the references, please go to:
www.sicot.org/enewsletter-81-scientific-debate



Hull Deformity Course SICOT Award



Bassel El-Osta

SICOT Associate Member & SICOT Newsletter Editorial Board Member – Tripoli, Lebanon

I was granted this award by SICOT and Hull Hospital jointly. I had always been interested in being part of this course as I had received a lot of positive feedback from previous delegates.

The course was held in Hull city, at a beautiful Mercure hotel. Everything started on Sunday in the early morning and the first person you met was the course organiser with her lovely smile and enthusiasm which made you feel extremely comfortable and ready for four days of very hard work.

The first impression was very positive, with one of the Course Directors, Mr Hemant Sharma, welcoming everyone and making them feel as comfortable as possible.

Starting the first day with the foot and ankle deformity, and with Mr Lahoti taking the lead, we knew that the most difficult part of this course would be passed to us as if it were the simplest thing. The day went by very quickly with saw bones, simple informative presentations, discussions, questions and answers. It was difficult to absorb everything, but it was nevertheless excellent.

The second day didn't differ from day one, but now we were learning the principles of Limb deformity. On the third day, we attended a Cadaveric lab, where we performed a number of procedures on cadavers. This was another amazing opportunity, enhancing our skills and learning curve. This is only a part, as we were again sawing bones, drawing lines and practising the art of deformity

correction. The last day was not less tense and we continued at the same level as in the previous three days. During the course, there were instructional lectures, clinically applicable, which were extremely useful. The faculty was amazing and of high standard, and everyone had an opportunity to do something.

This is the first course I have ever attended where there is real drawing, real pictures, real thinking. The lecturers put a lot of effort into giving us a take-home message in an amazing style. We always thought that limb reconstruction was "a piece of cake". The attitude of the faculty, who are world renowned, was wonderful and positive. They were always approachable and they kept going with us until the final minute.

Altogether, the course is of a very high standard, perfectly organised, and indeed informative and enjoyable. There were 50 candidates from all over the world, and my only observation is that this course is more suitable to doctors who are reaching the end of their training or are already junior consultants rather than candidates who are at the beginning of their training.

I am pretty sure that this course will become more and more popular and many SICOT members will be putting more effort into winning this remarkable prize. In future, it would be a good idea to double the prize and grant it to two awardees.

I would like to thank SICOT, Mr Sharma, Mr De Kiewiet, and the entire faculty for this amazing learning course.



2016 TCH/SICOT Research Fellowship Report



Dhavalkumar J. Patel

SICOT Associate Member – Ahmedabad, India

I would like to thank SICOT and Dr Dormans for giving me this opportunity. I would also like to thank Ms Mary Riordan and Mr Cody Sanderson for their help and support during the communication to set up the process for me to be in the United States from India for this fellowship. It is a privilege and honour to write the experience report for my TCH/SICOT Research Fellowship at the Texas Children's Hospital (TCH).



Dr Dhavalkumar J. Patel & Dr John Dormans

Texas is the second largest state of the United States and the Texas Medical Center, where the TCH is located, is the largest medical centre of the United States. It is an advanced tertiary care hospital, clinical training and research centre and an academic hospital affiliated to the Baylor College of Medicine.

I joined as a research fellow on 1 April 2016 at the Texas Children's Hospital. I met my mentor, Dr John P. Dormans, Chief of the Department of Paediatric Orthopaedics at TCH. Dr Dormans welcomed me with a humble smile and introduced me to the whole orthopaedics department. He guided me during my research projects to obtain a more positive outcome from my research work.

There was a department conference every Thursday morning where interesting post-operative cases and the pre-operative clinical findings, X-rays and management decisions of cases were discussed. Dr Dormans has established a full working research department which consists of a research director, research fellow, research assistants, research coordinator, and so on.

The fellowship was well planned with opportunities to attend clinical, academic and research programmes. It was a valuable experience for me in terms of the research skills and communication skills to manage the patient. The knowledge and skills acquired from this fellowship is priceless and abundant and will help me in strengthening my capabilities. I observed a wide variety of paediatric orthopaedic cases during my fellowship in clinics and in OR during my research work which broadened my knowledge. I attended a Texas Children's Hospital's surgical research day where I had an opportunity to expand my knowledge with the latest research work from all over the hospital. I also attended the grand rounds.

I collaborated with faculties here at TCH in writing scientific clinical research projects and this was the best research experience for me. I worked with Dr Harris, Dr McKay, Dr Phillips and Dr Hill. Their guidance and support was motivating and invaluable for me during the whole journey.

I worked with Dr Harris to be a co-investigator for one of her current research projects. She guided me with her knowledge and skills during the whole project. I also worked with Dr McKay. He taught me many new things and several new examination and operative details during clinics and OR observation. I also started an individual project with Dr Phillips.

I would like to thank all the staff members of the Texas Children's Hospital Clinical Care Center for their support during my fellowship and I would especially like to mention Ms Sha'Tia Safford, Ms Erica Gonzalez, Ms Ifeoma Inneh, Mr Cody Sanderson, and Ms Theodora Browne.

The fellowship was truly an experience which will remain in my memory for years to come. I will surely be using the experience received in my future orthopaedic practice, which I am sure will be beneficial to my patients and their families.

I would like to express my gratitude to SICOT for this prestigious fellowship and would like to thank Dr Dormans for this wonderful opportunity.

38th SICOT Orthopaedic World Congress



30 November - 2 December 2017
Cape Town  South Africa

Welcome Message from Doron Frantzen, Congress President



On behalf of the SICOT Congress Organising Committee, I would like to invite you to the 38th SICOT Orthopaedic World Congress from 30 November to 2 December 2017. Only for the third time on African soil, the meeting will be hosted in Cape Town, South Africa, at the most southern part of the continent.

Cape Town is the gateway to Africa and it was from here that Dr David Livingstone embarked on his explorations of the continent.

The city is a perennial favourite with visitors and locals alike. Overshadowed by the majestic Table Mountain, Cape Town offers spectacular scenery and is a renowned food and wine capital. The New York Times voted Cape Town the world's number one city to visit in 2014 and the UK's Telegraph newspaper recently voted Cape Town as the Best City in the World for the fourth consecutive year. Condé Nast Traveler magazine currently recognises Cape Town as the world's number one food city.

Participants can expect modern infrastructure, a legacy of South Africa's successful hosting of the 2010 FIFA World Cup, and opportunities to explore this compact city and its environs. Very few places offer the variety that Cape Town provides. One can enjoy a full day of the Congress and still

have time to watch the sunset over the Atlantic Ocean from the top of Table Mountain. For those wishing to arrive early or extend their visit, Cape Town is directly connected to the Kruger National Park and Botswana for safaris as well as to Victoria Falls.

The academic programme promises to include world standard orthopaedics inclusive of lecture presentations and workshops for the more general orthopaedic surgeons as well as super-specialists. Internationally acclaimed invited speakers will ensure that trainees and experts will be up to date with the latest modern orthopaedic technology and evidence-based medicine.

Welcome to Cape Town!



For more information, please visit www.sicot.org/cape-town

Editorial Department

Editorial Secretary: Hatem Said

Associate Editors: Syah Bahari & Mohamed Sukeik

Editorial Production: Linda Ridefjord

Editorial Board: Ahmed Abdel Azeem, Bassel El-Osta, Alexander McLawhorn

SICOT aisbl, Rue de la Loi 26 – b.13, 1040 Brussels, Belgium

Tel.: +32 2 648 68 23 | E-mail: edsecr@sicot.org | Website: www.sicot.org

