On behalf of the Hungarian Orthopaedic Society, I had the opportunity to join the EFORT Visiting Fellowship in 2005. I was selected for the fellowship at the Annual Congress of the Young Hungarian Orthopaedic Surgeons in 2004 from those colleagues who were the best in their scientific session.

As the EFORT Visiting Fellowship gives the participant the opportunity to chose a host institute, I was looking for an orthopaedic facility with high standards, offering good experience, learning and exchange of knowledge. As I have had a major interest in foot and ankle surgery, I decided to go to Bristol to join Mr. Ian Winson at the AVON Orthopaedic Centre at Southmed Hospital. Although we have a long history in foot surgery in my Orthopaedic Department at the University of Pécs in Hungary, it is more in the field of pediatric foot disorders leaving the adult foot problems with a need for advancement.

During my 3 weeks stay I aimed to participate in the full range of medical care including surgical interventions and outpatient surgery, as well as to gain insight to the training programme and postgraduate education. I could also get an impression about the structure of the National Health System in the UK with its pros and cons.

Not surprisingly, the most interesting part of my visit was the time I spent in the operating theatre. Unfortunately the NHS policy did not allow me to be actively involved in operations. I could observe a wide range of operations regarding the foot and ankle problems some of which I had never seen before. The most frequent operations I have seen on hindfoot were arthrodeses of different joints including ankle arthrodesis, subtalar arthrodesis, and triple arthrodesis. The most impressive of all was the arthroscopic ankle arthrodesis, which takes up the 90 percent of ankle joint arthrodeses in their present routine. Based on the experience and results of more than two hundred arthroscopic ankle arthrodeses that Mr. Winson performed, it has several advantages regarding the minimally invasive surgical approach, time of hospitalization, or high risk patients with diabetes. Most of the patients underwent different arthrodeses had rheumatoid arthritis and planovalgus deformity, but tarsal coalitions and cavovarus deformities were also operated. An additional new moment in arthrodeses was that the cancellous autologus bone grafts used to enhance the formation of bony coalition was harvested from the proximal tibia, leaving less complications at the donor site.

Arthroscopy was also routinely used in posttraumatic cases for articular debridement and to assist MACI (Matrix-associated Autolog Chondrocyte Implantation) in the ankle joint. Operations performed on the forefoot were metatarsal osteotomies and metatarsophalangeal arthrodesis on the first ray, and forefoot reconstructions by means of Stansby and Oxford procedures as well as forefoot arthroplasties.

An even more usefull part of my visit was the participation in the outpatient clinic. I could learn a lot about surgical indications, non surgical treatment options and a more biomechanical way of thinking in dealing with foot and ankle problems. I have seen several patients with total ankle replacement, which I could not observe in the operating theatre in the three weeks, unfortunately. We discussed the indications and long term results of ankle arthroplasty, as well as some technical details of implantation. This helped me to understand the primary concepts of ankle replacement, which is different from that of total hip or total knee replacement. Although ankle replacement is not a generally available option in Hungary today, within a few years it might be a more widely used procedure.
The application of local anaesthetics and steroid intraarticular injections in ankle joint, subtalar joint and in midtarsal joints has a good diagnostic and sometimes therapeutic value. It is applied under either ultrasound or image intensifier control, and is effectively managed by a tight cooperation with radiologists. We also use steroid injections on foot, but mainly for the ankle joint and sinus tarsi. The more extensive use of intraarticular injections should be incorporated in our practice as well.

There were two patient groups having a systemic disease with foot manifestations that were managed on especially high level by means of collaborating specialists of different fields. One of which was the large group of rheumatoid patients, who were seen both the rheumatologist and the foot and ankle specialist orthopaedic surgeon at the same time. The other group was of the diabetic patients. On this outpatient clinic the foot specialist orthopaedic surgeon, the vascular surgeon and the diabetologist were seeing the patients with foot problems and were helped by podologists. This was very impressive and also should be adapted in my home country as well. The setting up of a interdisciplinary treatment plan and a coordinated therapy makes the treatment of these patients much easier, faster, more effective, and probably more cost-effective.

During my stay I could see the structure of orthopaedic training, including postgraduate sessions. According to my experience, the UK has a thoughtful and effective training system which ensures that residents will finish the training as well-trained and experienced orthopaedic surgeons.

Finally, I have to express my thanks to the EFORT and the Hungarian Orthopaedic Society for this opportunity to gain very useful experience in a well established health system. Special thanks to Mr. Ian Winson, consultant orthopaedic surgeon at Avon Orthopaedic Centre in Bristol, who hosted me and showed me a frank example of how to practice as an orthopaedic surgeon. I would also like to thank to Dr. Claire Topliss who guided me throughout my stay.

Matyas Czipri MD
University of Pécs
Faculty of Medicine
Department of Orthopaedic Surgery

Pécs, 12th of May 2005