



EFORT NEWSLETTER

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DIAGNOSIS EUROPE'S GOING GREY

An orthopaedic specialist at a Swiss hospital (who shall remain nameless) recently made the following observation: „The phenomenon of rampant aging is of orthopaedic interest for three reasons: for one, orthopaedic specialists can look forward to an increase in business. For another, there is the issue of social responsibility. And finally, we're not getting any younger ourselves!”

As we all know, the bulge in senior citizens is due not only to improved life expectancy but also to a drop in the birth rate, which, according to the UN, means an enormous financial burden especially on emerging nations. Member states, therefore, need to commit themselves to a sustainable international plan of action designed to guarantee the rights of older people. The long-term strategy of such a plan must include the development of guidelines for predicting the aging curve, ensuring access to social and sanitary facilities and establishing the means of counteracting discrimination. >>



The Tower of Belém in Lisbon is on the UNESCO World Heritage List

WHY TO ATTEND THE 7TH EFORT CONGRESS AND GO TO LISBON?

BECAUSE IT IS:

- “State of the Art in Orthopaedics” - high scientific level (800 best abstracts will be presented out of 3800!)
- More than 5’000 of your colleagues will be present to meet and share ideas with
- Speciality Day with ARTOF, EAMS, EHS, EPOS, ERASS, ESSKA, SECEC, and many more!
- Very well organised
- Great culture and excellent dining in Lisbon
- Best time of the year to visit Portugal

The registration fee, travel to Lisbon and accomodation is modest:

Flights from central Europe	150.- *
Accomodation (4 nights)	440.- *
Registration fee (on site)	350.- *
Daily costs (lunch, dinner, bus for four days 4 x 40.-)	160.- *
TOTAL to enjoy 4 days in Portugal (including meeting registration)	Euro 1’100.- *

* prices are subject to change



Prof. George Bentley
EFORT President 2004-2005

EDITORIAL

Dear Colleagues

As is the case for the media in general, a newsletter's quality can surely be measured by the response it elicits. It's a shame I didn't count the number of spontaneous reactions to our last edition; they certainly added up to a heap of praise for our publication. Our readers are less generous, on the other hand, with their criticism - I assume they're just being polite.

In fact I am sorry that readers aren't as scolding with the editors as in times past. Compliments may be nice, but they won't get you very far. Constructive criticism, however, is the best incentive in our never-ending process of self-improvement.

When I say constructive criticism I am thinking of a colleague's will to make a real contribution to increasing the quality of one's work. In the case of a newsletter, such a contribution might take the form of submitting an exemplary article for consideration by the editorial board - and by exemplary I mean not only entertainingly written but praxis-oriented in its concerns. After all, an article is only of use if it can offer its reader something of practical value. And I am not only referring to value in the professional sense: we also welcome submissions that afford their readers pleasure and diversion. Let no one say in future that we orthopaedic specialists are a *sobre* lot!

Therefore, dear colleagues, I ask that you help the Newsletter continue to develop by showering us with excellent stories, reports, news and tips. For my part, I look forward to one feature remaining unchanged: our fine mixture of items of internal interest to EFORT with articles by outside contributors. For in contrast to certain other professional associations, we are open to the world and ready to enter into dialogue with it. And I am proud of us for it.

Yours sincerely

A handwritten signature in black ink that reads "George Bentley".

Prof. George Bentley
President

CHANGING DISEASE GROUPS

Snappy catchwords like „greying society” refer to a fundamental challenge facing Western European countries, and one which is growing in seriousness. The demographic pyramid will soon have been stood on its head as the average age across most of Europe continues to rise steadily.

Society's rampant aging is one of the reasons for an acceleration in the spread of certain diseases, including in addition to orthopaedic complaints such things as kidney ailments. Kidney problems, of course, are associated with the widespread condition of diabetes mellitus, particularly type 2. In Germany alone, six million diabetics constitute a considerable risk group for kidney ailments. Another such risk group is made up of those afflicted by hypertension. At current rates we may assume that, in the near future, almost half of all Europeans will suffer from high blood pressure, although most of them will not realise it. Such people naturally are at greater risk for illnesses of the kidneys, as are diabetics.

ACTIVE AGING

From 15 to 16 November 2000, 250 participants convened in Brussels, among them political movers and shakers, representatives of both employers and workers, and specialists in the field. They had come together to consider strategies and approaches to the project of „active aging”, and their focus was on measures aimed at integrating older people into their own aging societies. The concept of active aging was discussed as a way to improve the conditions for growing old in a society itself undergoing such a change. Active aging involves adapting our lifestyle so as to produce longer-lived, more robust, healthier citizens, and thus to allow such people to take advantage of new opportunities.

Practically speaking, this means leading more health-conscious lives, working longer, retiring later and remaining active even after retirement. The call for active aging is intended as an encouragement to lead better lives, and not as a curtailment of

existing rights. This also means, however, that the healthcare system itself requires an overhaul.

According to a broad consensus of experts, active aging constitutes a business-friendly socio-political strategy for integrating older citizens into society in a way that is consistent with the demands of healthcare providers. In her opening address, the cabinet member Barbara Helfferich stressed the possibility of deploying active aging to achieve the delicate balance sought by the conference participants, and thus to create the conditions necessary for taking the next crucial steps. Gabrielle Clotuche, a director on the European Commission who presided over the opening events, indicated her great satisfaction at the fact that the topic of aging had won an important place on the European agenda, thanks to the UN's International Year of Older Persons.

A LOOK TO THE EAST

At the 5th European Health Forum held in 2002 in Austria, Nata Menabde of the WHO noted the rapid growth of social inequity. While the average life expectancy for men in EU member states has risen from 56 in 1970 to just over 60 in the 1990s, she said, the opposite trend has been observed in countries in Central and Eastern Europe, where average life expectancy for that group sank to 54 over the same period. The development in Russia has been even more alarming, with life expectancy collapsing to the incredible average age of 48 smack in the middle of the „transition period“ of the 1990s. Across the Commonwealth of Independent States, meanwhile, men were living an average of only 45 years during that period, although the statistics had begun to improve slightly towards the end of the 1990s.

It is remarkable that such obvious deteriorations in the general health level are directly linked to unfavourable economic developments. With the exception of Hungary, Poland and the Czech and Slovak Republics, the former East-Bloc countries have seen a drop in their gross domestic product (GDP) since 1990, as well as a gen-

eralised shrinking of tax revenues. And while in the EU an average 8.6 percent of GDP is used to cover public health costs, Russia invests only 2.2 percent in its healthcare.

With just under a thousand hospital beds per 100,000 inhabitants in the Soviet Union in 1980, the CIS has inherited far greater care facilities than those enjoyed by Western Europe, which at the time boasted "only" just under 600 hospital beds per 100,000, a figure that has since dropped below 500. And yet the number of beds available does not, of course, say much about the quality of stationary treatment. Meanwhile, despite the availability of beds, the number of actual hospital stays in the CIS has sunk drastically, principally because of the high fees charged patients directly.

Most of the specialists in public health agree that there is an inverse correlation between high deductibles and the general level of health. In view of the fact that the demands made on the medical establishment have kept pace with the rise in technical standards, we have seen a concomitant increase in the urgent need to satisfy elementary medical requirements. That is one of the reasons why our colleagues from Eastern Europe deserve our solidarity. They need our help in overcoming obstacles which are ruins of the past political system.

WHO'S GOING TO PAY

The financing of healthcare is a delicate issue as the European population grows ever older. The present figures show 16 percent of Europeans older than 65, and forecasts suggest that this will have increased to 27 percent by 2010. The ranks of the „very old“, meanwhile (those over 80), may well grow by 50 percent over the next 15 years. For this reason, many politicians have reached the conclusion that the insurance industry must be Europeanised; individual leaders, meanwhile, are also calling for a concentration of the most advanced technologies in so-called competence centres. Whether any of this will

have an effect on costs, however, is a question that goes beyond our scope here.

„Orthopaedic specialists are concerned with people and their mobility“, said Professor Richard Windhager at a conference in Graz, clearly alluding to the slogan of the International Bone and Joint Decade. „Whether for conservative or operative therapy,“ he went on, „in interventions by molecular biologists or genetic therapists, Austria needs more orthopaedic specialists in order to improve the quality of life of an aging population.“ Objection: not only Austria. Europe as a whole needs more orthopaedic specialists! ■



WHO IS WHO

"THE EUROPEAN ORTHOPAEDIC COMMUNITY IS DISTINGUISHED BY ITS COSMOPOLITANISM"

Prof. Pavel Dungal (57) works at the Orthopaedic Clinic of the Charles University in Prague. An active participant in EFORT since its creation, he has attended all of our congresses and was until recently a member of the Executive Committee. EFORT Central Office (ECO) met with him to discuss his extraordinary commitment to the association.

ECO: "Prof. Dungal, what was the exact nature of your duties on the EFORT Executive Committee?"

PROF. DUNGL: "There is a very clear divi-

sion of labour at EFORT. I was responsible for the Travelling Fellowship and considered it my main duty to professionalise that service, in addition to organising two trips a year. Of course, this was easier than it sounds, because I was able to build on the work begun by Professor Niki Bohler. In keeping with EFORT guidelines, too, I was supported in my bid for the Executive Committee by the national orthopaedic associations not only of the Czech Republic but also by its Slovakian, Austrian and Polish counterparts.”

ECO: *“What do you mean by professionalising the Travelling Fellowship?”*

PROF. DUNGL: “The word ‘travelling’ smacks of tourism, and of course any serious travel requires a professional tourist organisation. For me, however, the indisputable focus of my programming was the professional background of this particular travel. For this reason I was always most interested in the exchange of orthopaedic expertise among my young (and even younger!) colleagues from countries with a range of medical traditions. This in turn led to the current insistence that each Travelling Fellow deliver a lecture at some point during the trip, which ensures that the Travelling Fellowship always provides each and every participant with the opportunity for professional enrichment.

ECO: *“Why do non-European orthopaedic specialists also take advantage of this service, now that you have turned it into an institution?”*

PROF. DUNGL: “You’re right: in addition to participants from more than 40 European countries we are constantly seeing guests from South Africa, South America and Asia as well. The European orthopaedic community is distinguished by just this sort of cosmopolitanism.”

ECO: *“As a citizen of the Czech Republic with many years of professional experience in Western Europe, you must surely be interested in promoting dialogue between orthopaedic specialists from formerly*

socialist countries and their colleagues in the West.”

PROF. DUNGL: “Of course. For forty years we were on the sidelines as the express train raced by us, with only very few of us getting a chance to jump aboard. And while we weren’t exactly standing still during that difficult period, we did have a completely different set of experiences to work with. And now that we are at last on the same train with the rest, we won’t be content as second-class passengers: we want to be seen as equal to the others. So any East-West dialogue worthy of its name must be a two-sided process, and not simply a monologue in disguise.”

ECO: *“You believe, then, that the last vestiges of a Communist healthcare system will soon have disappeared?”*

PROF. DUNGL: “That’s not what I said. We are the heirs to a tricky legacy, and it may take two or three generations for our outdated structures and backward-looking apparatuses to truly become history. As we strive to overcome these obstacles, what we imperatively require is the solidarity of our European colleagues.”

ECO: *“That sounds like real commitment. So why are you leaving the EFORT Executive Committee?”*

PROF. DUNGL: “I am a member in long standing of EPOS, the European Paediatric Orthopaedic Society, which champions among other things clinical practice, scientific research and the improvement of paediatric care. In fact, I have now been made president of this key association. So my resignation from the EFORT Executive Committee has to do exclusively with time and energy constraints. And besides, my period in office was over. I look back on five years of stimulating work on that body.”

ECO: *“Your successor, Prof. Miklos Szendroi, comes from Hungary. Do you have any advice for him?”*

PROF. DUNGL: “Prof. Szendroi and I have been close friends for over 25 years. You should know that orthopaedic specialists

were accustomed to staying in close contact behind the Iron Curtain. So my Hungarian successor has an intimate knowledge of what I was up to during my tenure. And I have not the least doubt that he will continue to expand and develop the services offered by EFORT in the spirit of our original charter. I wish him from the bottom of my heart all the best!”

ECO: *“Your resignation from the Executive Committee has apparently not prevented you from remaining actively interested in the future of EFORT. For instance, you are currently campaigning for an EFORT Congress in your hometown of Prague. Why the patriotism?”*

PROF. DUNGL: “You’re quite right, I am in fact giving my all for the EFORT Congress 2009 to be held in Prague. And there are many good reasons for my advocacy. Prague is a real jewel of a city: practically nowhere else in Europe can you find such a pristine old town centre. We have a brand-new congress centre, one that can easily hold 10,000 people and offers 6000 square metres of exhibition space - and they’re planning to expand it by 2006. Plus we have extensive experience organising major conferences. And if you visit the hotels in the vicinity of the new centre, you will feel as enthusiastic as I do. But quite apart from the infrastructure, I am interested in cost. A congress in the Czech Republic could cost EFORT between 30 and 40 percent less than one held in other Western European cities. And it would also be affordable for my colleagues from the former East Bloc.”

ECO: “Prof. Dungl, we would like to thank you for the opportunity to talk with you. You are more European than most of us!” ■

HOSTING CONGRESS

WHO WILL HOST THE 9TH EFORT CONGRESS IN 2009?

Six European capitals are vying for the honour of hosting the 9th EFORT Congress. Knowing that choosing a winner will not be child's play, EFORT has elaborated a set of criteria. In addition to these criteria, as well as to a cost-benefit analysis, the selection process will also be guided by a whole series of subjective impressions. The top priority for a winning city, of course, will be the matter of accessibility and general security. But the range of facilities on offer is also key. After all, participants should be able to have a good time as well, so we'll have to think about tourist attractions, too. The editorial board of the EFORT Newsletter asked the professional congress organisers (or PCOs) involved to provide it with three decisive arguments apiece in favour of their cities.

WHERE IS EUROPE'S HEART?

We haven't received much hard data; rather, the PCOs have sent a lot of frothy advertising copy. When asked where the heart of Europe lies, for instance, the Germans think Berlin is the obvious choice. The Czechs, however, see Prague as the centre of Mitteleuropa. And then of course

Vienna and Budapest also claim to lie at the heart of Europe. They could all be right. The Turkish PCOs, meanwhile, are making hay of the fact that Istanbul lies on the edge of Europe: "Istanbul has cultures and traditions that blend East with West and Mediterranean with Anatolian", they say. "Each civilisation that has made its home in Istanbul has left its mark in some way, and the result we see today is a city that could only have come about after thousands of years of diverse cultures each adding a little something." As for Madrid, its wild card is the Spanish beach scene: "Those visitors who would like to stay in Spain longer can benefit from the country's ideal climate and a series of extraordinary possibilities for the month of September."

WHO IS THE FAIREST IN ALL THE LAND?

The question of geographic location, however, pales in comparison with the comparative evaluation of tourist attractions. All six candidates claim a unique historical legacy on display to congress participants. Berlin, for example, boasts the Pergamon Museum and its antiquities, in addition to 148 other remarkable collections, while Prague is one big dream: the city's historical centre was rightfully added in 1993 to the UNESCO World Heritage List. For its part, Budapest cuts an equally dashing figure: "2000-year-



old Roman remains and 400-year-old Turkish monuments stand side by side with turn-of-the-century and modern buildings, as well as fine Romanesque churches, splendid palaces and mansions now housing museums and hotels." And of course Vienna need fear no comparison. "Walk in the footsteps of the Habsburgs," say its boosters, "visit the splendid baroque Schönbrunn and the Spanish Riding School, or stroll along the magnificent Ring Boulevard and take a look at the heart of the former vast Habsburg Empire, the Imperial Palace." The Turks, meanwhile, are no slouches when it comes to blowing their own horn: "Istanbul also offers organisers a wide variety of pre- & post-tour options, from cruises and overland expeditions to cultural tours and just relaxing on some of the Mediterranean's finest beaches. Delegates can choose from the elegant and the exotic, the relaxing and the rugged, the ancient and the astonishing."

And if you think that the competition can be settled on gastronomic grounds alone, then you need to revise your prejudices with a





little European tour. We've eaten our way through all six metropolises and can report that they are all equally perilous to the health of participants suffering from hypertension, obesity or liver steatosis, threatening as their cuisines do a veritable bombardment of calories and lipids.

ROOM FOR EVERYONE

Let's focus on the facts, such as the location of the congress centre, the infrastructure and technical aids. In all of these regards, my friends, we can report that Europe has made a massive effort at improvement. In Prague, for instance, "the Congress Centre is fitted with high-quality equipment in terms of audiovisual technology, air conditioning, energy connections and communications, ISDN data links, GSM and modern hall technologies." As for

space problems, Madrid sees no need to worry. "It should be pointed out that the capacity of the IFEMA Convention Centre is more than sufficient to be the venue of an EFORT Congress", write the Madrid PCOs. "Indeed, it has over 20 rooms which can hold between 150 and 3000 people, 25 smaller parallel rooms for seminars and small meetings, a 21,000-square-metre hall which can house both the trade exhibition and the Internet area, meeting points and rest areas." Still, the Berlin-Prague-Vienna-Budapest-Istanbul axis can certainly hold its own!

WARNING: ROADBLOCKS AHEAD!

Political correctness demands that we confine ourselves here to positive comments on the six European candidates. For their part, the PCOs have taken pains to avoid

even the suggestion of a danger lurking in the cities they champion. Nevertheless, one of the six candidates has the dubious honour of being Europe's noisiest city, while the centre of another threatens to wash congress participants over the side of a bridge amid streams of hysterical tourists. Still another features a resident staff of con artists going about their daily business of robbing visitors blind, while in a fourth the fitness-oriented participant may well need a pulmonary biopsy following a jog around town. We leave it to you, dear colleagues, to discover which city suffers from which urban malaise... Presentation and vote to follow at the General Assembly. ■



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EFORT PORTAL

MASSIVE JUMP IN EFORT PORTAL VISITORS

Effective information management calls among other things for the ability to convey key news in the most concise possible form without sacrificing any of its substance. In this regard our EFORT portal has once again done a yeoman's service. And it has met with the appreciation of our members, as evidenced by user statistics. Beside steady growth on information we see the progress as a result of the recent Soft

Relaunch of the Welcome Page and main navigation. The three main areas Public - Members - Extranet are easily found and accessible.

Additionally there has been added a new zone where all EFORT Societies can present themselves professionally. Society Gallery is a cost free tool to put each Society into the spot light especially for the upcoming important Event "Lisbon 2005".

One index of the site's usage (and of its benefits) is the veritable explosion in congress registration after each publication:

following the electronic appearance of the Newsletter on 26 January and 24 February 2005, we enjoyed a boost of 650 and 700 registrations, respectively, to the EFORT Congress in Lisbon.

The site's impact was no doubt helped further by our new practice of publishing "must-read" articles on a monthly basis. These brief items appear in collaboration with the Bone and Joint Decade/MSeC as well as with the Journal of Bone and Joint Surgery (UK volume). Here are a few samples, just to whet your appetite:

ABSTRACTS: THE TOP FIVE

RADIOGRAPHIC PROGRESSION OF KNEE OA

"Thrust during ambulation and the progression of knee osteoarthritis." Chang A, et al. Arthritis & Rheumatism 2004; 50:3897-3903.

"The effect of body weight on progression of knee osteoarthritis is dependent on alignment." Felson DT, et al. Arthritis & Rheumatism 2004; 50:3904-3909.

The first paper showed that varus thrust is associated with increased odds of radiographic progression in medial compartment knee OA even after adjustment for varus malalignment and body mass index at baseline. This effect is presumably mediated by increases in dynamic adduction moment during gait.

The second paper showed that there was effect modification between baseline malalignment and body mass index in predicting radiographic progression in knee OA. There was an association between increasing body mass index and radiographic progression; however, when malalignment was considered, the association remained significant only in those knees with moderate malalignment at baseline. The authors suggest that weight loss to reduce progression may not be effective in those with severely malaligned knees. Professor Marc Hochberg, MD, MPH, University of Maryland, USA.

IMPROVING OUTCOME IN FRACTURE HEALING

"Perspective: Parathyroid hormone - a drug for orthopedic surgery?" Skripitz R, Aspenberg P. Acta Orthop Scand 2004; 75 (6):654-662.

Basing their findings on a review of clinical and preclinical studies, the authors suggest that there are good reasons to believe that PTH treatment may stimulate fracture healing and improve implant fixation. Professor Anders Rydholm, Rydholm, Professor of Orthopaedic Surgery, Lund University, Sweden

VERTEBRAL FRACTURES

"Association of Severe Vertebral Fractures with Reduced Quality of Life. Reduction in the incidence of severe vertebral fractures by teriparatide." Crans GG, Silverman SL, Genant HK, et al. Arthritis & Rheumatism 2004; 50:4028-4034.

Parathyroid hormone, in carefully regulated doses, can significantly reduce the risk of new or worsening of existing vertebral fractures. Edward D. Harris, Jr., MD, George DeForest Barnett Professor of Medicine Emeritus at Stanford University, USA.

ADJUNCTIVE THERAPY IN KNEE OA

"Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee." Berman BM, Lao L, Langenberg P et al. Annals of Internal Medicine 2004; 141:901-910. Viewable at: <http://www.annals.org/cgi/content/full/141/12/901>

This paper provides, in a placebo-controlled study, evidence that acupuncture seems to offer improvement in both function and pain relief as an adjunctive therapy for osteoarthritis of the knee. Edward D. Harris, Jr., MD, George DeForest Barnett Professor of Medicine Emeritus at Stanford University, USA.

ANTI-SM AND ANTI-RNP ANTIBODY TESTS

"Guidelines for Immunologic Laboratory Testing in the Rheumatic Diseases: anti-Sm and anti-RNP antibody tests." E Benito-Garcia, PH Schur, R Lahita et al. Arthritis Care and Research 51: 1030-1044.

This article provides an evidence base for the role of the use of anti-Sm and anti-RNP antibody tests in lupus patients and other rheumatic conditions. The discussion includes their sensitivity and specificity for diagnosis and their use for prognosis determination, e.g. nephritis and central nervous system involvement. Dr Bridget Griffiths, Consultant Rheumatologist, Freeman Hospital, Newcastle upon Tyne, UK. Speciality: SLE. ■

HEALTH AND STUDIES

PUBLIC HEALTH STRATEGY TO REDUCE THE BURDEN OF MUSCULOSKELETAL CONDITIONS

Prof. Anthony D Woolf, Dr. Kristina Åkesson, Dr. Juliet Compston, Prof. Karl-Göran Thorngren, Prof. Piet van Riel and Dr. Alex Watt for the European Bone and Joint Health Strategies Project

The European Action Towards Better Musculoskeletal Health (EATBMH) is a collaboration of the Bone and Joint Decade, EULAR, EFORT and The International Osteoporosis Foundation, (IOF) supported by the European Commission, which has developed strategies to prevent and manage musculoskeletal conditions.

The EATBMH strategies were developed by experts in rheumatology, orthopaedics, trauma, public health, health promotion and policy.

STRATEGY FOR MAINTAINING MUSCULOSKELETAL HEALTH

- Physical activity
- Ideal weight
- Balanced diet, recommended daily calcium and vitamin D
- No smoking
- No alcohol abuse
- Accident prevention programmes to avoid musculoskeletal injuries
- Health promotion at workplace; sports programmes to prevent abuse of musculoskeletal system
- Greater public awareness of musculoskeletal issues. Information on prevention, management of conditions and early diagnosis

The strategies seek to benefit all sufferers and make integrated recommendations for prevention and treatment. They focus on osteoarthritis, rheumatoid arthritis, back pain, osteoporosis, major limb trauma and occupational and sports injuries.

The report highlights the burden of musculoskeletal conditions in terms of numbers affected, work disability and use of services. Nearly one quarter of adults in Europe suffer longstanding problems which limit

everyday activity by almost 50 percent. Such conditions (excluding trauma) account for almost 25 percent of the total cost of illness in Europe, are the second most common reason for consulting a doctor and in most countries make up from 10 to 20 percent of the primary-care burden. They are the greatest cause of problems limiting work; up to 60 percent of people on early retirement or long-term sick leave cite such problems.

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Prevention of these conditions is clearly key, and risk factors for musculoskeletal health must be recognised. These factors may be used to identify those for whom other interventions are indicated and include age, obesity, lack of physical activity, smoking and various injuries. Many of these are risk factors for other chronic conditions; the strategy for maintaining musculoskeletal health (Table 1) thus promises broad benefits.

Many interventions reduce pain. Tissue damage can be prevented in rheumatoid arthritis with disease-modifying drugs and bone mass improved with drugs such as bisphosphonates in osteoporosis. Joint-replacement surgery for osteoarthritis and rheumatoid arthritis or repair of osteoporotic fractures increases quality of life. Clear recommendations for the treatment of the various conditions affecting those at highest risk, those in the early phases, and those with established problems have been established.

The report recommends strategies combining evidence-based interventions for the various conditions. The strategies are aimed at prevention in the general population, at individuals at greatest risk for conditions, and at impact-reduction in sufferers. The strategies seek common recommendations to maintain or improve musculoskeletal health whatever the underlying condition. They also combine the effect of evidence-based interventions with the aims of sufferers, caregivers and health-care providers.

Those at greatest risk should be encouraged to take risk-reduction measures, including a healthy lifestyle and avoidance of disease risks. A case-finding approach can identify high-risk individuals who will benefit most from evidence-based interventions. For example, assessment of fracture risk should use risk-factor profiling and bone-density assessment, along with such things as bisphosphonates in those at highest risk.

Those with earliest symptoms should receive a prompt, appropriate assessment of their problem, followed by proper care

and education in self-management. People in the early stages of rheumatoid arthritis, for instance, should be expertly diagnosed within six weeks of symptom onset; disease-modifying anti-rheumatic drug (DMARD) treatment should accompany symptomatic therapy and rehabilitation as soon as the diagnosis is conclusive, along with self-management programmes and information on lifestyle and treatment.

Those with an established condition and pain, functional impairment, limited activity and restricted participation should get fair access to appropriate care to reduce pain and the consequences of their conditions. Most outcomes are best achieved with good pain and disease management and disease rehabilitation, provided as cost-effectively as possible in the proper environment. Thus people with established osteoarthritis should receive pain management including the use of topical, simple and anti-inflammatory analgesics (NSAIDs); glucosamine sulphate, chondroitin sulphate, hyaluronic acid and I/A therapies (including corticosteroids, hyaluronic acid and tidal irrigation) are also possible. Normal biomechanics should be restored, e.g. by osteotomy and ligament and meniscal surgery where indicated. Joint-replacement surgery should be considered for end-stage joint damage causing unacceptable pain or limitation of function. Rehabilitation can improve everyday life. The use of aid devices and environmental adaptations in the home and workplace should be considered.

The implementation of these strategies to improve musculoskeletal health across Europe is the next challenge. ■

Download the report at www.efort.org

InductOs® (dibeternin alfa) - ESSENTIAL INFORMATION

Refer to Summary of Product Characteristics (SPC) before prescribing.

Indication:

Treatment of acute fibular fractures in adults, as an adjunct to standard conservative open fracture reduction and intramedullary nail fixation.

Presentation:

InductOs 12 mg kit for implant: The kit has three components: dibeternin alfa powder (recombinant human bone morphogenetic protein 2), water for injections, and a collagen matrix sponge.

Dosage and Preparation:

InductOs is to be prepared (using sterile technique) immediately prior to use. The dibeternin alfa should be reconstituted with 8.4 ml of solvent to produce a 1.5 mg/ml solution, 8 ml of which is distributed uniformly into the collagen matrix. After having been saturated with the dibeternin alfa solution, the sponge must not be squeezed. Once prepared, the product should be left to stand for at least 15 minutes, but a maximum of 2 hours.

Note: Concentrations greater than 1.5 mg/ml have not been studied in humans.

Implantation:

InductOs (dibeternin alfa solution on the collagen matrix) is implanted (folding and/or cutting as necessary) after standard fracture and wound management (i.e., at the time of definitive soft-tissue closure). The accessible surface area of the fracture should be covered with InductOs (maximum diameter 2 cm), with as much muscle and soft-tissue coverage as possible.

During implantation, care should be taken to handle the loaded matrix sponge to avoid excessive loss of fluid.

Place InductOs so that it bridges the fracture region and makes good contact with the major proximal and distal fragments.

InductOs may be placed into a dead (loosely packed) after having been killed, rolled or wrapped, as the geometry of the fracture requires. InductOs does not provide mechanical stability and should not be used to fill gaps in the presence of compressive forces. There are no data on concomitant use with bone graft.

Once InductOs is implanted, do not irrigate the wound.

Contraindications:

Hypersensitivity to dibeternin alfa, bovine type I collagen or any other excipient; infected (or actively) fracture site infection; persistent compartment syndrome or non-mechanical malunion of compartment syndrome; pathological fracture (including Paget's Disease); active malignancy; ongoing treatment for malignancy; pregnancy.

Warnings/Precautions:

Before implanting InductOs, ensure adequate fracture reduction and stabilisation, neurovascular status and haemostasis, and absence of large segmental defect repair of long bones.

InductOs can cause initial necrosis of surrounding trabecular bone. Therefore, it should not be used for direct application to trabecular bone. In addition, the performance of the InductOs as an adjunct to other fracture methods (e.g., plating and screws, external fixation) is unknown.

Repeat use of InductOs is not recommended.

Safety and efficacy have not been established in patients with known autoimmune disease. No studies have been performed in patients with hepatic or renal impairment.

InductOs may cause heterotopic ossification in the surrounding tissues, which can result in complications.

Adalimumab (dibeternin alfa) was developed by 4.4% of patients receiving InductOs vs 0.0% in the control group. Antibodies to bovine type I collagen were developed by 15.1% of patients receiving InductOs vs 11.0% of control patients (who did not receive the matrix as part of their treatment). No patient developed anti-human collagen antibodies.

Special risk/benefit consideration should be given for patients who have previously received injectable collagen. Where an undesirable effect with immunological background is suspected, the possibility of an immune response to the product should be evaluated.

Caution should be exercised in varying markets (as when safety and effectiveness have not been established). There has been no known case of overdose.

Undesirable Effects:

Adverse events observed in clinical trials were generally representative of the morbidity associated with orthopaedic trauma or surgical procedure.

The incidence of frequent (>10%) undesirable effects was similar in both control and InductOs groups, although pain and infection (local specific to the fractured limb) were more frequent in the control group.

The incidence of common (1-10%) undesirable effects was similar in both control and InductOs groups, although increased anaemia (without overt signs of anaemia) in InductOs treated patients, headache, tachycardia, and hypotension was observed significantly more frequently in the InductOs group.

Classification: Product subject to medical prescription.

Basic NHS Cost: InductOs 12mg kit for implant - £234

Marketing Authorisation Number: EU1/01/236/001

Marketing Authorisation Holder: Wyeth Europe Ltd., Bartonshele Lane, South, Tapscott, Middlesbrough, Cleveland, S65 0PR, United Kingdom.

[Essential Information prepared 1 April 2005.]

Further information may be obtained from:

For UK and Ireland:
Wyeth Pharmaceuticals, Bartonshele Lane South,
Tapscott, Middlesbrough, Cleveland S65 0PR, UK

Telephone (switchboard): +44 1628 606177
Telephone (Medical Information): +44 1628 45339

[Essential Information consistent with the Summary of Product Characteristics current at date of product launch.

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- **Fewer infections**^{ref 1}
in association with Gustilo-Anderson grade III injuries 24% vs 44%, $p=0.0219$

* recombinant human bone morphogenetic protein-2

Ref 1: Recombinant Human Bone Morphogenetic protein-2 for treatment of Open tibial fractures. BESTT study group, BJIS 84-A, 12, 2123-2134

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BMP Lunchtime Symposium
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EFORT CONGRESS 2005

A GREAT COLLABORATIVE EFFORT

By Prof. Karl-Göran Thorngren, Chairman EFORT Scientific and Educational Committee

Scientific contributions to the EFORT congresses increasing. A total of 2339 abstract submissions were received for the EFORT 2003 congress in Helsinki, while for the EFORT 2005 Lisbon congress 3800 abstracts have been submitted via the new web-based EFORT abstract handling system. In Helsinki the EFORT programme covered four full days and featured 16 parallel sessions consisting of 985 free papers, 42 symposia and 29 instructional course lectures. At the same time 1139 posters were presented. The speciality societies had a whole day for their programmes.

For the Lisbon 2005 congress the scientific committee has decided to condense the programme to 12 parallel sessions. This will make choices easier for the participants, because there will be fewer parallel sessions devoted to the same topics. At the same time a higher attendance in each room can be expected, which will mean a greater demand for seats in each of the twelve auditoriums. The Lisbon congress centre meets these criteria.

A THOROUGH EVALUATION PROCESS

As for previous congresses the abstracts have been assessed by a group of scientific

evaluators suggested by the national associations and including the speakers in the symposia and instructional course lectures as well as many of the EFORT board members. In total 74 scientific evaluators have been working on the EFORT 2005 Lisbon scientific evaluation process. Each abstract is evaluated by two scientific advisors and graded according to a scheme comprising four categories, each with grades from 1 to 5. The highest total score is considered the best. Furthermore, issues of relevance and statistical calculations have also been taken into consideration. At the evaluation the scientific advisor has access only to the title and the text of the abstracts, with names of authors and their institutional affiliations electronically removed from their work packages (which typically consist of 150-200 abstracts for each evaluator).

The Lisbon congress will feature 36 symposia, including five pro and con symposia and 22 instructional course lectures. Given the constraints of the four-day programme of 12 parallel sessions and considering the space needed for symposia and instructional course lectures, there is room for around 1000 oral presentations. The poster space in Lisbon is limited to 500 posters on simultaneous display. If the posters are changed each day it is possible to exhibit close to 2000 posters; alternatively, the same 500 posters could simply be left up for the full duration of the meeting. The shorter exhibition time could be compensated by electronic access to all posters

during the congress. These circumstances inevitably lead to a need to increase the rejection rate compared to previous congresses. The selection between different presentation categories is dependent on the total grades awarded by the scientific advisors, with the mean of the points given by the two evaluators being calculated. The authors' desired presentation form has been followed as much as possible. The abstracts with the highest scores have been used to develop the free paper sessions, and those with the lowest scores have been earmarked for rejection.

REASONS FOR REJECTION

All rejections have been specifically evaluated by the central core of the scientific committee. Abstracts without real scientific content, i.e. those indicating simply that a study is under way or vaguely describing a treatment process, have of course been rejected. Due to the large number of abstracts submitted, reports of single cases have also mostly been rejected, as have studies including a comparatively low number of patients. Testing of new concepts has been favoured over local applications of well-known principles. The intention in the future is to open a specific section of the EFORT website where single case reports can be continuously accessible. This new presentation form will make it easier to rapidly collect multiple cases of rare disorders and complications and thereby, it is hoped, to facilitate general conclusions of benefit for the profession.

Information about the category of acceptance was made available on the congress website at the beginning of 2005. As usual, prepaid application for the congress is a prerequisite for being kept on the programme.

Some groups of authors have delivered several abstracts. Due to the competition for space and attention, each first author is only allowed to present three oral presentations during the meeting and a maximum of two presentations will be accepted in one session, regardless of their evaluation grades. Remaining high-scoring abstracts have been accepted as posters.

SPECIALITY SOCIETIES WILL BE INVOLVED IN THE SYMPOSIA

Beginning at this congress in Lisbon (to be intensified at the EFORT 2007 congress in Florence) the speciality societies will be invited to be more involved in the planning and performance of the symposia and ICL lectures. The traditional speciality day during the meeting will change its format, a process already partly under way at the Lisbon meeting. The speciality societies

will have their own meetings during the morning session, whereas the afternoon will feature a mixed congress programme. The intention is to better mix the speciality societies' programmes into the general EFORT programme. Experience gathered at the Lisbon meeting will guide future evolution.

An interesting scientific congress programme is the result of great teamwork by all involved. I would like to express my gratitude to the scientific advisors, the members of the scientific committee and particularly the special workshop group, who finalised the programme during the hectic weeks before Christmas 2004. First of all, however, I thank all EFORT members who have submitted abstracts to the Lisbon congress. Together with symposia and ICL lectures, they will form the core of a series of intriguing free paper sessions and posters that will make the EFORT 2005 Lisbon congress an outstanding event. ■

HIGHLIGHT

EFORT CONGRESS LISBON 2005: SYMPOSIUM ON BLOOD LOSS AND BLOOD MANAGEMENT

The EFORT Congress in Lisbon will include a particularly topical symposium devoted to "Blood management in orthopaedic surgery". Moderated by Prof. Roger Lemaire from Belgium, the symposium will feature as discussants Göran Benoni from Sweden, Peter Earnshaw from the U.K. and Etienne Pitsaer from France.

Blood loss from surgery includes a visible part: the external blood loss during the operation and in the drains (if any), but there is also an occult blood loss in the tissues, which is often underestimated. The total blood loss can be calculated based on the drop noted in haemoglobin and haematocrit levels, taking into account the patient's blood volume (related to weight and gender), and the amount of blood transfused. Occult blood loss may represent up to 60% of the overall blood loss.

Blood loss may be important enough to require compensation, which has been traditionally by transfusion of homologous blood. The latter has been reconsidered for a number of reasons, including the fear of virus transmission (now reduced thanks to improved serological tests) and also a demonstrated increased risk for infection, due to immunomodulation.

The requirements for allogenic blood transfusion can be reduced in a number of ways.

1. Reducing blood loss is possible through basic technical measures, and through the use of local or systemic haemostatic agents. Fibrin sealant sprays and local application of tranexamic acid have been shown to reduce the overall blood loss and the need for blood transfusion following several major orthopaedic interventions. Systemic administration of tranexamic acid has also been shown to reduce blood loss and blood transfusion. Desmopressin, aprotinin and recombinant factor VII have

UPCOMING ...

- 15th Annual Meeting EORS Lisbon, P, 2-4 June 2005
- 24th European Paediatric Orthopaedic Society Meeting, 6-9 April 2005
- 7th European Foot and Ankle Society Instructional Course, 6-7 May 2005
- British Orthopaedic Association: Annual Congress 2005, 21-23 September 2005
- 19th Annual Meeting of the German-Speaking Paediatric Orthopaedic Society (19. Jahrestagung der Deutschsprachigen Vereinigung für Kinderorthopädie), 11-12 March 2005
- AE Instructional Course Spine Surgery, 13-18 March 2005
- 5th Biennial Congress of the International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine, 3-7 April 2005
- The Second Scandinavian International Seminar on Fractures in Children, 21-24 September 2005
- 72nd Annual Meeting of the American Academy of Orthopaedic Surgeons, 23-27 February 2005
- World Congress on External Fixation 2005, 26-28 May 2005
- XXIII SICOT/SIROT Triennial World Congress, 2-9 September 2005
- Triennial Meeting of the International Federation of Foot and Ankle Societies (IFFAS), 14-18 September 2005

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also been studied, but were found to be less cost-effective.

Tourniquet use, as well as avoiding wound drainage, will reduce intra-operative external blood loss but not the occult internal blood loss, which may even be increased. Tradeoffs on drainage, such as delayed or intermittent drainage, may help reduce the postoperative external blood loss as compared with conventional suction drainage, but not the occult blood loss.

Preoperative administration of aspirin or NSAIDs, as well as chemical DVT prophylaxis with low molecular weight heparin have been found to increase blood loss. Aspirin and NSAIDs should be discontinued well ahead of the operation, and mechanical rather than chemical DVT prophylaxis should be given due consideration.

2. Increasing the preoperative erythrocyte stock is another way to reduce the requirement for blood transfusion. This can be

achieved with preoperative administration of erythropoietin (rHuEPO), together with iron supplementation. Several regimens have been tried; it appears that administration of 600 IU/kg SC once a week during the 3 weeks before operation is as effective as daily administration of 300 IU/kg daily for 14 days, while being 50% less costly and more convenient for the patients.

Iron therapy can be used to correct anaemia due to iron deficiency, or to optimise the effect of EPO therapy. Absorption of oral iron is poor, and IV administration of a polysaccharide-iron complex is more effective. There is little conclusive data on the efficiency of oral iron therapy pre- and postoperatively.

A number of studies have shown that the preoperative haemoglobin and haematocrit level is the best predictor of transfusion risk. In patients with moderate anaemia (Hb between 10 and 13 g/dl) with expected moderate blood loss (900 to 1800 ml), preoperative administration of EPO

significantly decreases exposure to allogenic blood.

3. There is now a consensus for lowering the transfusion trigger below the traditional values of 10 g/dl Hb and 30% Ht, down to 8 g/dl and even 7 g/dl in patients with a good cardiovascular condition.

4. Preoperative donation of autologous blood may help in reducing the exposure to allogenic blood transfusion. It does have some limitations however: the blood marrow does not always respond as expected, and a number of patients who have predonated blood will come anaemic to operation and will require autologous transfusion to start with and sometimes also homologous transfusion; it should be kept in mind that transfusion, even of autologous blood, carries a risk of complications. On the other hand, a number of patients who have predonated will not need any transfusion, and a high proportion of predonated blood is



likely to be wasted. The procedure, if used on a systematic basis, is not cost effective.

5. Re-infusion of shed blood, either intra-operatively (cell saver) or postoperatively (re-infusion of drained blood) may help reduce the need for homologous transfusion.

The cell saver is cost effective only in case of major blood loss such as in revision THR (average: 500 ml re-infused) or in scoliosis surgery. Re-infusion of drained blood is limited to blood collected within 6 hours after surgery, with a maximum of 1000 ml. Its efficiency is unpredictable; it may be of value in patients with a small body weight and blood volume.

6. Blood substitutes have been investigated, such as perfluorocarbons or solutions of human haemoglobins, but they are still in an investigative phase.

Before any operation, some basic steps should be followed: the first step is to evaluate the anticipated blood loss, and to figure out whether this is higher or lower than the allowable blood loss for that specific patient. The allowable blood loss will depend on the preoperative blood volume and haematocrit, and also on the haematocrit that is to be maintained postoperatively for that specific patient. If the expected blood loss appears to exceed the allowable blood loss, an algorithm must be followed so as to reduce the risk for homologous transfusion: this includes attention to all the factors which we have mentioned, and optimal use of the various possibilities available to increase the preoperative

haemoglobin level and to reduce intra- and postoperative blood loss, in addition to either autologous blood donation and/or re-infusion of recuperated blood.

Blood management must be given appropriate consideration in all surgical procedures; it requires a customised approach. ■

CLINICAL TRENDS

ACUTE REHABILITATION TO IMPROVE CONVALESCENCE

The German medical journal *Deutsche Arztezeitung* reports on a new trend about which we may well be hearing a lot in the days to come: "As early as possible!" That's the motto of a burgeoning therapeutic movement known as acute rehabilitation. It involves interdisciplinary teams of physicians performing the work of intensive neuromuscular function training right in the intensive-care ward.

At present, systematic acute rehabilitation is being offered in Germany in pilot projects at 12 acute-care clinics. Acute rehabilitation calls for a comprehensive rehabilitation programme to begin as early as during the acute phase of treatment, so as to dispatch the patient already "pre-trained" into the care of traditional rehabilitation specialists.

Rehabilitation physician Dr. Jean-Jacques Gläsener heads the department of transdisciplinary early rehabilitation at the Allgemeines Krankenhaus St. Georg (AKH) in Hamburg.

Together with colleagues from internal medicine, orthopaedics and neurology, the AKH specialists offer their services as a mobile early-rehabilitation team based in a specially designed area of the AKH's intensive-care ward. Therapy begins while the patient is still receiving artificial respiration. The team assist their intensive-care colleagues in weaning patients from the respirator and beginning independent feeding. Patients are moved to a special early-rehab station equipped with monitors and continuous positive airway pressure

(CPAP) devices no sooner than 24 hours following extubation.

"Candidates for acute rehabilitation come from a whole range of disciplines", notes Gläsener in Berlin. This includes stroke sufferers as well as cardiac-surgery patients and accident victims. Gläsener sees the main duty of such interdisciplinary teams of physicians and therapists as the development of patients' communication skills by means of tracheal canules, as well as the improvement of their trunk stability, manual coordination and ability to swallow.

Additional studies will have to be conducted in order to collect the concrete data needed to judge the actual medical benefits of the process. ■

INDUSTRIAL NEWS

EUCOMED:

"WHY ARGUE ABOUT THE COST OF HEALTHCARE AND NOT ABOUT THE COST OF MOTORWAYS?"

EUCOMED Director General Maurice Wagner called for a genuine single market for medical technology in the keynote speech he delivered today at the Frost & Sullivan Medical Technologies Europe 2005 Executive Summit in London. EUCOMED, the European voice of the medical technology industry, represents 25 European associations and 4500 designers, manufacturers and suppliers of medical technology used in the diagnosis, prevention, treatment and amelioration of disease and disability.

The European Union has successfully established a balanced and predictable regulatory framework for medical devices, which should in theory allow every patient, wherever he or she may be in the EU, to receive the latest and most appropriate medical treatments and technologies.

However, several hurdles follow the CE-marking process. The key issue has to do with pricing and reimbursement procedures at member-state level, which often

delay the introduction of innovative medical technology and may vary from country to country, or indeed from region to region within the same country, as is the case in Spain and Italy. "You may end up with products that are available in one country, not in the other. Thus, one cannot speak of a genuine single market", Wagner noted.

There may be other barriers to clinician and patient access to medical technology, such as technology assessment programmes in member states that effectively delay or prevent the launch of innovative medical technology, as well as insufficient training and knowledge concerning the use of new treatments on the part of medical professionals.

Maurice Wagner also emphasised that healthcare must be seen as a long-term investment and not as a short-term cost. In his words, "Why argue about the cost of healthcare and not about the cost of motorways?" ■

EFORT NEWS

EFORT GRAND FELLOWSHIP AWARD

By Prof. Miklós Szendroi, MD, PhD, DSc, Chairman "Prices and Travelling" of the Fellowship Commission

EFORT has established an award - the Grand Fellowship (Jaques Duparc Fellowship) for the authors of the ten best posters shown at the congress poster session. Each of these Fellowships is worth a thousand euro, which can be used by the authors to visit an orthopaedic clinic, department or institution for a minimum four-week stay.

The top-ranked sixty posters will be marked at the poster session and a committee nominated by the EFORT Executives will then choose the ten best. The results will be made public at the closing ceremony, where the names of authors and the titles of their posters will be announced. The ten best posters will also be presented on the EFORT website. ■

THE JOURNAL OF BONE AND JOINT SURGERY – BRITISH VOLUME ABSTRACTS AVAILABLE ONLINE IN 7 LANGUAGES

The Journal of Bone and Joint Surgery - British Volume (JBJS [Br]) is a leading Journal in orthopaedics and is read worldwide.

At the start of 2004 the JBJS [Br] teamed up with EFORT in order to get the abstracts of all JBJS [Br] articles translated into as many languages as possible. This hugely successful relationship has resulted in the translation of all JBJS [Br] abstracts into 6 languages (French, Spanish, Romanian, Polish, Czech and Russian). The JBJS [Br] also hosts Italian translations of all abstracts, as well as some Korean and Japanese articles.

The translations can be found on our website at www.jbjs.org.uk and are linked to each article via flags representing the languages available.

The JBJS [Br] is extremely grateful to the EFORT central office for the hard work



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involved with the distribution and collation of all the translated abstracts. A full list of translators involved with this project is available at www.jbjs.org.uk. ■

EFORT AND EUCOMED PROMOTE ETHICAL BEHAVIOR IN BUSINESS PRACTICE

Sound relations between physicians and the orthopaedic implant industry are essential in order to provide innovative

solutions and scientific support reaching a high standard of patient care. In this respect, some authorities have taken the position that industry sponsorship of certain activities, such as education, medical congresses and related entertainment may influence a physician's choice of products or services. Thus, the need of establishing standards for proper interactions between the medical device industry and health care providers became obvious.

EUCOMED, the European Medical Technology Industry Association, representing directly and indirectly more than 4'500 business entities operating in Europe and through out the world, have taken the lead to develop guidelines and published recently its Code of Business Practice.

All EUCOMED members (including, but not limited to, all major orthopaedic device manufacturers) have adopted the Code of Business Practice taking into account the scrutiny and the rapidly changing health care environment. Consistency of practices across Europe and beyond is beneficial for and other health care professionals as well as to the industry that are critical to the delivery to lifesaving and life enhancing medical technology.

EUCOMED is highly committed to encourage physicians and professional societies, like EFORT, to be aware of the fact, that the required interactions between physicians/professional societies and the Partnership with physicians is vital to secure continuous development and improvement of medical consulting are still legitimate, given a reasonable diligence.

Training and education of surgeons, physicians on the safe and effective use of complex medical technologies will, and must continue.

Finally, health care and industry professionals must collaborate to ensure patient access to state-of-the-art medical care.

The entire Code of Business Practice and supplementary information can be obtained from EUCOMED's website: www.eucomed.org.

EFORT encourages its members to get familiar with the Code and its importance for a prosperous cooperation between physicians and the industry for the patients benefit. ■

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